



EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community
Epidemiology Work Group

Highlights and Executive Summary

January 2010

NATIONAL INSTITUTE ON DRUG ABUSE



COMMUNITY EPIDEMIOLOGY WORK GROUP

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

Division of Epidemiology, Services and Prevention Research

National Institute on Drug Abuse

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The information presented in this Executive Summary is primarily based on CEWG area

reports and meeting presentations prepared by CEWG representatives for the January 2010 CEWG meeting. Data/information from Federal sources supplemental to the meeting presentations and discussions have been included in this report to facilitate cross-area comparisons.

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Foreword

THIS EXECUTIVE SUMMARY PROVIDES A SYNTHESIS OF findings from reports presented and data prepared for the 67th semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in San Diego, California, on January 20–22, 2010. The CEWG is a network of researchers from sentinel sites throughout the United States. It meets semi-annually to provide ongoing community-level public health surveillance of drug abuse through presentation and discussion of quantitative and qualitative data. CEWG representatives access multiple sources of existing data from their local areas to report on drug abuse patterns and consequences in their areas and to provide an alert to potentially emerging new issues.

Local area data are supplemented, as possible, with data available from federally supported projects, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN), Drug Enforcement Administration (DEA) National Forensic Laboratory Information System (NFLIS), and the DEA Heroin Domestic Monitor Program (HDMP). This descriptive and analytic information is used to inform the health and scientific communities and the general public about the current nature and patterns of drug abuse, emerging trends, and consequences of drug abuse.

The CEWG convenes twice yearly, in January and June. For the June meetings, CEWG representatives prepare full reports on drug abuse patterns and trends in their areas. After the meeting, a Highlights and Executive Summary Report is produced, and the full CEWG area reports are included in a second volume. For the January report, the representatives present an abbreviated report to provide an update on data newly available since the prior June report and to identify significant issues that have emerged since the prior meeting. These abbreviated reports, or Update Briefs, are included in this Executive Summary,

along with highlights from the meeting and cross-site data compilations.

The majority of the January 2010 meeting was devoted to the CEWG area reports and presentations. CEWG area representatives presented data on recent drug abuse patterns and trends. After the area reports, breakout groups were formed to discuss key drug abuse indicators and to review meeting findings by area and region. In addition, discussions were held on emerging drug problems and issues across CEWG areas. Presentations on drug abuse patterns and issues were also provided by guest researchers from Canada, Europe, and the Caribbean. Other highlights of the meeting included an update from DEA representative Scott Rowan, M.A., on trends in heroin and cocaine trafficking; an update on levamisole and other issues from Nicholas Reuter, M.P.H., from SAMHSA's Center for Substance Abuse Treatment; an overview of the National Southwest Border Counternarcotics Strategy by M. Fe Caces, Ph.D., from the Office of National Drug Control Policy; a presentation on the National Drug Intelligence Center's SENTRY Program by Susan A. Seese, Ph.D.; a presentation from Kean McAdam, M.S.S.I., on the High Intensity Drug Trafficking Area Program and United States–Mexico border drug trafficking; and a presentation from Kimberly Brouwer, Ph.D., on drug use research projects in the San Diego–Tijuana border region.

This Highlights and Executive Summary Report for the January 2010 CEWG meeting includes the CEWG Update Briefs and International Reports and highlights findings from the CEWG area reports and discussions.

Moira P. O'Brien

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Department of Health and Human Services

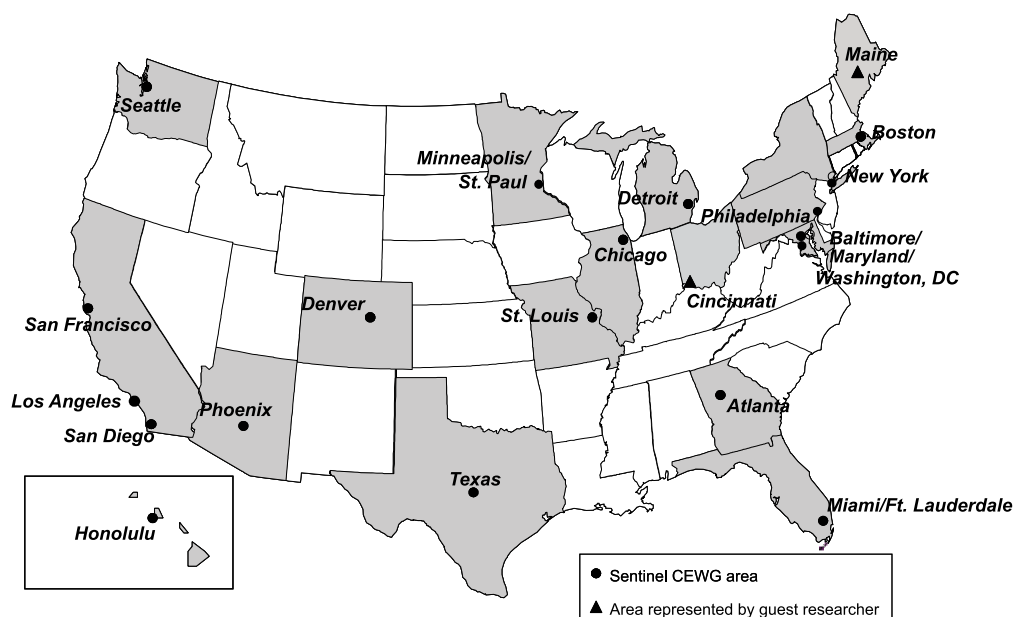
Section I. Introduction

THE 67TH SEMIANNUAL MEETING OF THE COMMUNITY Epidemiology Work Group (CEWG) was held on January 20–22, 2010, in San Diego, California. During the meeting, researchers from 20 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided for 18 sentinel areas that have contributed to the network for many years, guest researchers from Cincinnati and Maine provided data from their respective areas, as did international representatives from Canada, Europe, and the Caribbean.

The CEWG Network

The CEWG is a unique epidemiology network that has functioned since 1976 as a drug abuse surveillance system to identify and assess current and emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/or different facets of the behaviors and outcomes related to drug abuse. The information obtained from each source is considered

a drug abuse indicator. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and different types of drug abusers (such as those who have been treated in hospital emergency departments, admitted to drug treatment programs, or died with drugs found in their bodies). Data on items submitted for forensic chemical analysis serve as indicators of availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas. The CEWG areas on which presentations were made at the January 2010 meeting are depicted in the map below, with one area presentation including data on Baltimore, Maryland, and Washington, DC.



CEWG Meetings

The CEWG convenes semiannually; these meetings continue to be a major and distinguishing feature of the workgroup. CEWG representatives and guest researchers present information on drug abuse patterns and trends in their areas, and personnel from Federal agencies provide updates of data sets used by the CEWG. In addition, time is set aside for question-and-answer periods and discussion sessions. The meetings provide a foundation for continuity in the monitoring and surveillance of current and emerging drug problems and related health and social consequences.

Through the meetings, the CEWG accomplishes the following:

- Dissemination of the most up-to-date information on drug abuse patterns and trends in each CEWG area
- Identification of changing drug abuse patterns and trends within and across CEWG areas

At the semiannual meetings, CEWG representatives address issues identified in prior meetings and, subsequently, identify drug abuse issues for follow-up in the future.

In addition to CEWG area presentations, time at each meeting is devoted to presentations by invited speakers. These sessions typically focus on the following:

- Presentations by researchers in the CEWG host city
- Updates by Federal personnel on key data sets used by CEWG representatives
- Drug abuse patterns and trends in other countries

Identification of changing drug abuse patterns is part of the discussions at each CEWG meeting. Through this process, CEWG representatives can alert one another to the emergence of a potentially new drug of abuse. The CEWG is uniquely positioned to bring crucial perspectives to bear on urgent drug abuse issues in a timely fashion and to illuminate their various facets within the local

context through its semiannual meetings and post-meeting communications.

Data Sources

To assess drug abuse patterns and trends, city- and State-specific data were compiled from a variety of health and other drug abuse indicator sources. Such sources include public health agencies; medical and treatment facilities; ethnographic research; key informant discussions; criminal justice, correctional, and other law enforcement agencies; surveys; and other sources unique to local areas.

Availability of data varies by area, so reporting varies by area. Examples of types of data reviewed by CEWG representatives to derive drug indicators include the following:

- Admissions to drug abuse treatment programs by primary substance of abuse or primary reason for treatment admission reported by clients at admission
- Unweighted estimates of drug-involved emergency department (ED) reports in the ED records from the Drug Abuse Warning Network (DAWN) *Live!* system and, when available, weighted estimates of drug-involved ED visits and rates per 100,000 population are utilized for reporting areas
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Administration (DEA) and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME) or local coroner offices or State public health agencies
- Arrestee urinalysis results and other toxicology data
- Surveys of drug use
- Poison control center data

Sources of data used by several or most of the CEWG area representatives and presented in this Highlights and Executive Summary Report are summarized below, along with some caveats

related to their use and interpretation. The terminology that a particular data source uses to characterize a drug, for example, cannabis versus marijuana, is replicated here.

Treatment data were derived from CEWG area reports. For this report, they represent data for 18 CEWG metropolitan areas and 5 States: Colorado, Hawaii, Maine, Maryland, and Texas. Recent or complete treatment admissions data were not available for Washington, DC. Data for several States are included with metropolitan data for comparison, including data for Colorado with Denver, Hawaii with Honolulu, and Florida with Miami/Dade County and Ft. Lauderdale/Broward County. The latter two counties in South Florida are part of the Miami Metropolitan Statistical Area (MSA). The reporting period is cited as the first half of calendar year (CY) 2009 (the first half of 2009), since all area representatives reported data for that time interval. Appendix table 1 shows overall treatment admissions data by drug and CEWG area for the current reporting period. Table 2 in section II and several tables in section IV (tables 3–4, 7, 10–11) and appendix table 1 also display cross-area treatment admissions data, as do several figures in section II (figures 2–4, 7, 12–13, and 18–20).

DAWN ED¹ Weighted Estimates for 11 CEWG areas for 2004 through 2008 were provided by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). However, the weighted DAWN ED estimates for one area, Seattle, are not included in this report at the request of the Seattle CEWG area representative, as he had unresolved concerns about the estimates for Seattle at the time this report was developed. Therefore, data for 11 CEWG areas from the DAWN system are reported here. The weighted DAWN data for 2004–2008 are presented in section IV as maps (figures 23, 25, 27, 28, 30, and 32) and in appendix tables 3.1–3.6

as estimated numbers and rates per 100,000 population for ED visits for selected drugs. DAWN ED data for particular CEWG areas are displayed in figures 8 and 9 in section II of this report. The data represent drug reports for drug-involved visits for illicit drugs (derived from the category of “major substances of abuse,” excluding alcohol) and the nonmedical use of selected pharmaceutical drugs. Nonmedical use of pharmaceuticals is use that involves taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement.

Nonmedical use may involve pharmaceuticals alone or in combination with other drugs, especially illegal drugs or alcohol. Since drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol), summing of drugs across categories is not recommended. A description of the DAWN system can be found at <http://dawninfo.samhsa.gov>. The estimates in section IV represent MSAs for all reporting CEWG areas, with three exceptions: New York City, which represents the Five Boroughs Division only; Miami, which represents the Miami/Dade County Division and the Fort Lauderdale Division (which includes Broward and Palm Beach Counties); and San Francisco, which represents the San Francisco Division only, including San Francisco, San Mateo, and Marin Counties.

Forensic laboratory data for a total of 22 CEWG sites were available for the first half of 2009. Data for all CEWG metropolitan areas in the first half of 2009 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. NFLIS is a program in

¹DAWN uses a national sample of non-Federal, short-stay, general surgical and medical hospitals in the United States that operate 24-hour EDs. The American Hospital Association (AHA) 2001 Annual Survey is the source of the sample. ED medical records are reviewed retrospectively for recent drug use. Visits related to most types of drug use or abuse cases are identified and documented. Drug cases encompass three visit categories: those related to illegal or illicit drugs; nonmedical use of prescription, over-the-counter, or other pharmaceutical drugs; and alcohol among patients under the legal drinking age of 21, and patients of all ages when used in combination with other drugs.

the DEA Office of Diversion Control which systematically and continuously collects results from drug analyses of items received from drug seizures by law enforcement authorities. Drug analyses are conducted by Federal (DEA) forensic laboratories and participating State and local forensic laboratories. As of January 2010, in addition to the DEA laboratories, the NFLIS system included 47 State systems, 96 local or municipal laboratories/laboratory systems, and 1 territorial laboratory, representing a total of 283 individual laboratories. These laboratories handled more than 88 percent of the Nation's nearly 1.2 million annual State and local drug analysis distinct cases. Data are entered daily based on seizure date and the county in which the seizure occurred. NFLIS provides detailed information on the prevalence and types of controlled substances secured in law enforcement operations and assists in identifying emerging drug problems and changes in drug availability and in monitoring illicit drug use and trafficking, including the diversion of legally manufactured drugs into illegal markets. A list of participating and reporting State and local forensic laboratories is included in Appendix A of the U.S. Drug Enforcement Administration, Office of Diversion Control (2009) report, *National Forensic Laboratory Information System: Year 2008 Annual Report* (Washington, DC: U.S. Drug Enforcement Administration)². Boston reports forensic drug seizure data from the Massachusetts Department of Public Health Drug Analysis Laboratory to supplement NFLIS reports. In most cases, data are for MSAs, rather than single metropolitan counties, but the exact geographic areas covered in this report are defined in appendix table 2. A map displaying NFLIS data for the first half of 2009 for 22 CEWG areas is included as figure 21 in section II, while a number of other figures and tables in section II (table 1) and section IV (figures 22, 24, 29, and 31, and tables 8, 9, 12, and 13), along with appendix tables 2.1–2.22, are provided to display the data on forensic laboratory drug items identified

for the period across areas. CEWG area Update Briefs in section III of this report also include NFLIS data for CEWG areas.

Average price and purity data for heroin for 21 CEWG metropolitan areas in CY 2008 (the most recent period available) came from the DEA report, *2008 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report*, published October 2009 (DEA-09022). This report is prepared by the Domestic Strategic Intelligence Unit of the Special Strategic Intelligence Section, and reflects analysis of program data to December 31, 2008. Data from this report are included for the following CEWG sites/areas: Atlanta, Baltimore, Boston, Chicago, Dallas, Denver, Detroit, El Paso, Houston, Los Angeles, Miami, Minneapolis/St. Paul, New York City, Philadelphia, Phoenix, St. Louis, San Antonio, San Diego, San Francisco, Seattle, and Washington, DC. In section II, figure 10, and in section IV, figure 26 and tables 5 and 6 show data for average price and purity for CEWG areas.

Illicit price data for CEWG metropolitan areas in CY 2008 were also provided by the report, "National Illicit Drug Prices," published in June and December 2008 by the National Drug Information Center (NDIC), U.S. Department of Justice. Data from these reports are included for the following CEWG areas: Chicago, Denver, Phoenix, St. Louis, and San Francisco. Information from the DEA report, *2008 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report*, published October 2009, was included in reports from Atlanta; the Baltimore/Maryland/ Washington, DC, area; Boston; Chicago; Denver; Philadelphia; St. Louis; and San Francisco.

DEA ARCOS (Automation of Reports and Consolidated Orders System) data were presented by CEWG area representatives in the following CEWG Update Briefs contained in section III: the report from the Baltimore/Maryland/Washington, DC, area, Detroit, Los Angeles, Miami/Dade and Fort Lauderdale/Broward Counties in South Florida, and Texas. Figure 15 in

²This can be found at <https://www.nflis.deadiversion.usdoj.gov/DesktopModules/ReportDownloads/Reports/NFLIS2008AR.pdf>.

section II of this report also contains ARCOS data. ARCOS is an automated, comprehensive drug reporting system that monitors the flow of DEA-controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level. The following controlled substance transactions are tracked by ARCOS: all Schedule I and II materials (manufacturers and distributors); Schedule III narcotic and gamma hydroxybutyric acid/hydroxybutyrate (GHB) materials (manufacturers and distributors); and selected Schedule III and IV psychotropic drugs (manufacturers only).

Local drug-related mortality data from medical examiners/coroners (ME/Cs) or State public health agencies were reported for 13 CEWG areas: the Baltimore/Maryland/Washington, DC, area, Boston, Cincinnati, Denver, Detroit, Los Angeles, Maine, New York City, Philadelphia, St. Louis, San Diego, Seattle, and Miami/Dade and Ft./Lauderdale/Broward Counties in South Florida. These are described in section III and shown in figures 5, 6, 11, and 17 in section II of this report.

Other data cited in this report were local data accessed and analyzed by CEWG representatives. The sources included local law enforcement (e.g., data on drug arrests); local DEA offices (DEA field reports); High Intensity Drug Trafficking Area (HIDTA) reports; arrestee drug information from the Arrestee Drug Abuse Monitoring (ADAM) II system; poison control centers and help lines; prescription drug monitoring systems; local and State surveys; and key informants and ethnographers (figure 16 in section II reports helpline call data, while figures 1 and 14 display probationer/parolee and arrestee urinalysis data, respectively).

A Note to the Reader—Caveats

Terminology and Geographic Coverage—

The CEWG representatives use existing data, which are subject to the definitions and geographic coverage of the source data. Representatives generally use the terminology as it is used in the data source. For example, many treatment systems use the phrase “other opiates” for classifying opiates³ or opioids⁴ other than heroin as the primary problem at admission. The term “other opiates” is therefore retained in this summary report, and the terms “other opiates” and “opioids” may be used in a single area report. Similarly, the term “prescription-type opioid” is used by some representatives to distinguish synthetic or semisynthetic opioids, such as oxycodone and hydrocodone, from heroin. The geographic coverage of data sources may vary within a CEWG area report. Readers are directed to the Data Sources paragraph in the CEWG area Update Briefs in section III for a more complete description of data sources used in specific areas. In this summary report, in most cases, the general name of the CEWG area will be used for data sources. For the DAWN and NFLIS data, the specific geographic coverage will be noted in footnotes. For example, appendix table 2 presents the NFLIS data for each area, and footnotes specify the coverage. The geographic coverage for the DAWN weighted estimates presented in this report has been described previously under Data Sources.

Local comparisons are limited, or must be made with caution, for the following indicators:

Treatment Admissions—Many variables affect treatment admission numbers, including program emphasis, capacity, data collection methods, and reporting periods. Therefore, changes in admissions bear a complex relationship to drug abuse prevalence. Treatment data on primary abuse of specific drugs in this report represent percentages of total admissions, both including and

³Opiate is defined as “any preparation or derivative of opium” by *Stedman’s Medical Dictionary* – 28th Edition, Lippincott Williams and Wilkins, Baltimore, MD: c. 2006.

⁴Opioid is defined as “Originally a term denoting synthetic narcotics resembling opiates but increasingly used to refer to both opiates and synthetic narcotics” by *Stedman’s Medical Dictionary* – 28th Edition, Lippincott Williams and Wilkins, Baltimore, MD: c. 2006.

excluding primary alcohol admissions. Percentage distributions based on total treatment admissions by drug, including primary alcohol admissions, were used for all cross-area comparisons. Data on demographic characteristics (gender, race/ethnicity, and age group) and route of administration of particular drugs were provided for some CEWG areas and reported in Update Briefs. The numbers of admissions for alcohol and other drugs in the first half of 2009 are presented for 22 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 2. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change. Most of the CEWG area representatives report Treatment Episode Data Set (TEDS)⁵ data accessed from local treatment programs or States, and these data are included in cross-area comparison tables in this report (table 2; section IV, tables 3, 4, 7, 10, 11, and appendix table 1).

ED Drug Reports—For this meeting report, weighted estimate data were provided to area representatives by OAS, SAMHSA, from the DAWN system for 2004–2008, with statistical tests of differences using *t*-tests and *p*-values. These data were used in area Update Briefs by all 11 of the CEWG area representatives for whom such data were available in the DAWN system: Boston, Chicago, Denver, Detroit, Houston (Texas), Miami, Minneapolis/St. Paul, New York City, Phoenix, San Diego, and San Francisco (estimates for

Seattle, although available, were not employed by the area representative and are not included in this report). When comparisons are made across time periods with a CEWG area, this caveat is needed: statements about drug-involved ED weighted rates in CEWG areas being higher or lower in 1 year than another year are only made when their respective *t*-test *p*-values are significant at the .05 level or below. Otherwise, no difference is reported.⁶

Forensic Laboratory Drug Items Identified—NFLIS includes drug chemistry results from completed analyses only; drug evidence secured by law enforcement but not analyzed in laboratories is not included in the NFLIS database. State and local policies related to the enforcement and prosecution of specific drugs may affect drug evidence submissions to laboratories for analysis. Laboratory policies and procedures for handling drug evidence vary, and they range from analysis of all evidence submitted to the laboratory to analysis of selected items only. Many laboratories did not analyze the evidence when a case was dismissed or if no defendant could be identified (see NFLIS Year 2008 Annual Report cited earlier). Differences in local/State laboratory procedures and law enforcement practices across areas make area comparisons inexact. Also, the data cannot be used for prevalence estimates, because they are not adjusted for population size. They are reported as the percentage that each drug represents of the total number of drug items seized and identified by forensic laboratories in a CEWG area, and cases are assigned

⁵TEDS is an administrative data system providing descriptive information about the national flow of admissions to specialty providers of substance abuse treatment, conducted by OAS, SAMHSA.

⁶Estimates of ED visits associated with misuse and abuse of drugs are derived by applying sampling weights to data from a stratified probability sample of hospitals. The estimates obtained are of drug-involved visits. A single ED visit may involve multiple drugs, which are counted separately. When ED visits involve multiple drugs, such visits appear multiple times in a table. Therefore, summing ED visits as reported in these tables will produce incorrect and inflated counts of ED visits. Combining estimates for categories of drugs is subject to a similar limitation. Multiple drugs may be involved in a single visit, so categories are not mutually exclusive and will not sum to 100 percent when percentages are calculated. Because multiple substances may be recorded for each DAWN case, caution is necessary in interpreting the relationship between a particular drug and the number of associated visits. It is important to note that a drug-involved ED visit is any ED visit related to recent drug use. This is the new definition of a DAWN case as of 01/01/03. One or more drugs have to be implicated only in the visit; they do not necessarily have to have precipitated or caused the visit. These are visits, not patients, such that they are duplicated numbers to an unknown extent rather than being unique numbers. See: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Drug Abuse Warning Network, 2006: National Estimates of Drug-Related Emergency Department Visits*. DAWN Series D-30, DHHS Publication No. (SMA) 08-4339, Rockville, MD, 2008.

to a geographic area by the location of the seizure event, not the laboratory. Because the method of case assignment for the data provided by DEA to the CEWG has changed recently to assignment based on the geographic location from which items were submitted for identification, rather than the location of the laboratory that performed the item identification, NFLIS data for 2007 onwards cannot be compared with pre-2007 data presented in prior CEWG reports. The nature of the reporting system is such that there may be a time lag between the time of seizure, the time of analysis of drug items, and the time of reporting to the NFLIS system. Therefore, differences in the number of drug items for a specified time period may occur when NFLIS is queried at different times, since data input is daily and cases may be held for different periods of time before analysis and reporting in various areas and agencies. Numbers of drug items presented in these reports are subject to change and may differ when drawn on different dates.

Deaths—Mortality data may represent the presence of a drug detected in a decedent or overdose deaths. The mortality data are not comparable across areas because of variations in methods and procedures used by ME/Cs. Drugs may cause a death, be detected in a death, or simply relate to a death in an unspecified way. Multiple drugs may be identified in a single case, with each reported in a separate drug category. Definitions associated with drug deaths vary. Common reporting terms include “drug-related,” “drug-detected,” “drug-induced,” “drug-caused,” and “drug-involved.” These terms may have different meanings in different areas of the country, and their meaning may depend upon the local reporting standards and definitions. Cross-area tabulations of mortality drug abuse indicators are not included in this report.

Arrest and Seizure Data—The numbers of arrests and quantities of drugs seized may reflect enforcement policy and resources, rather than level of abuse.

Local Area Comparisons

The following methods and considerations pertain to local area comparisons:

- Local areas vary in their reporting periods. Some indicators reflect fiscal periods that may differ among local areas. In addition, the timelines of data vary, particularly for death and treatment indicators. Spatial units defining a CEWG area may also differ depending on the data source. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether a city, a single metropolitan county, an MSA, or some subset of counties in an MSA. In some instances, data were compiled by region defined by the U.S. Census as northeastern, southern, midwestern, and western regions. Texas is included in the western region in this report, rather than in the census-defined southern region, based on member recommendations concerning area comparability of drug patterns and similarity of population characteristics to other western areas.
- In section IV of this report, percentages for treatment program admissions are calculated and presented in two ways, excluding primary alcohol admissions from the total on which the percentages are based and including primary alcohol admissions in the total on which percentages are based. However, all cross-area comparisons use only the latter measure.
- All treatment data in the cross-area comparison section of this report cover January through June of 2009, which is characterized as the current reporting period. Weighted ED estimates are available for 2004–2008, and statistically significant differences over time within an area are provided in appendix tables 3.1–3.6 and section IV, figures 23, 25, 27, 28, 30, and 32 of this report.
- Some indicator data are unavailable for certain cities. Therefore, the symbol, “NR,” in tables refers to data not reported by the CEWG area representative.
- The racial/ethnic population compositions differ across CEWG areas. Readers are directed to the individual CEWG area Update Briefs in section III of this report for information regarding treatment patterns and trends pertaining to race/ethnicity, age, and gender, if discussed.

Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the January 2010 CEWG Meeting

THE CORNERSTONE OF THE CEWG MEETING IS THE CEWG area report. Area representatives provide 20-minute presentations summarizing the most recent data pertaining to illicit and abused drugs and noting changes since the prior meeting. These data are viewed as indicators of the drug problem in an area. Indicators reflect different aspects of the drug abuse situation in an area, such as prevalence of abuse of drugs (e.g., survey findings), consequences of drug abuse (e.g., drug-involved ED reports, substance abuse treatment admissions, and drug-related deaths), and availability of abused substances or law enforcement engagement (e.g., drug seizures). Qualitative information from ethnographic studies or local key informants is also used to describe drug use patterns and trends, and this may be particularly informative in the early identification of new issues or substances being misused or abused.

In presenting area reports, CEWG representatives are invited to use their professional judgment and knowledge of the local context to provide an overall characterization of the indicators for their areas, as possible, given available data; that is, to assess whether indicators appear to be stable, increasing, decreasing, or are mixed so that no consistent pattern is discernable. CEWG representatives may also provide an overall characterization of the level of the indicators as high, moderate, or low, or identify when particular drugs are considered to be the dominant drugs of abuse in an area. Some indicators are sensitive to recent changes in local policy or law enforcement focus; therefore, representatives use their knowledge of the local context in describing and interpreting data available for their area.

Contained in this volume for each CEWG area represented at the meeting are Update Briefs, which document and summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the January and June 2009 meeting reports. The availability of data varies by area. Readers are directed to the Data Sources section of the Update Briefs in section III of this report to determine which data sources were reviewed for particular areas.

Subsequent to the CEWG meeting, data available across a majority of CEWG areas, such as substance abuse treatment admissions and information from NFLIS and DAWN, are reviewed. These data are presented in section IV of this report and in appendix tables 2.1–2.22 and 3.1–3.6. Highlights from these cross-area tabulations are also included in this section.

For the January 2010 CEWG meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas for the first half of the most recent calendar year. Following the January 2010 area presentations, CEWG representatives convened in small work groups organized by region to discuss local issues in the regional context and to facilitate the identification of issues and patterns within and across regions. Key findings and issues identified at the CEWG meeting are highlighted in section II, with more detail provided in the Update Briefs in section III.

Findings in this report are summarized by type of substance, but it is important to note that polysubstance abuse continues to be a pervasive pattern across all CEWG areas.

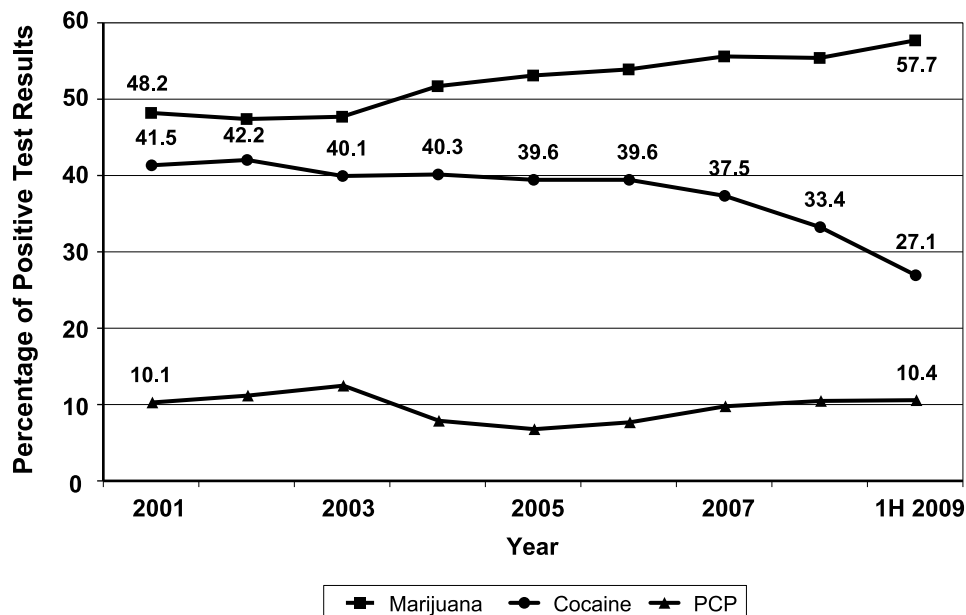
Cocaine/Crack

- *While cocaine remained a major drug of concern in CEWG areas in all regions of the country—the Northeast, South, Midwest, and West—declining indicators were evident in all but six of the CEWG areas, based on area representative reports (New York City, Atlanta, Detroit, and San Francisco, where indicators were mixed; Chicago where they were stable; and Honolulu where cocaine use and abuse indicators increased). Declines were emphasized by area representatives in the South and the Northeast.*
- In the northeastern region, declines in cocaine indicators were noted in Philadelphia, Boston, Maine, and New York City.
 - The area representative for Philadelphia reported an important decline in cocaine use and abuse in the first half of 2009; cocaine abuse declined in indicators from treatment admissions data, mortality data, drugs seized and identified by NFLIS, and Philadelphia

Adult Probation and Parole Department (APPD) analysis data. Among probationers and parolees who were tested for the first time (APPD data), cocaine-positive screens declined from 41.5 percent in 2001, to 37.5 and 33.4 percent in 2007 and 2008, respectively, and to a low of 27.1 percent in the first half of 2009 (figure 1).

- Cocaine continued to figure prominently at high levels in Boston indicators, although treatment admissions stabilized, and cocaine calls to the drug abuse helpline decreased from 19 percent in FY 2008 to 15 percent in FY 2009.
- In Maine, cocaine indicators continued a decline first noted in 2008; declines in all indicators (deaths, arrests, treatment admissions, and drug seizures) continued into the first half of 2009. For example, cocaine/crack arrests have dominated the illicit drug activity of the Maine Drug Enforcement Agency in recent years, but the proportion

Figure 1. Percentage of Positive Urinalysis Test Results for Selected Illicit Drugs Detected Among Adults on Probation or Parole for the First Time, Philadelphia: 2001–the First Half (1H) of 2009

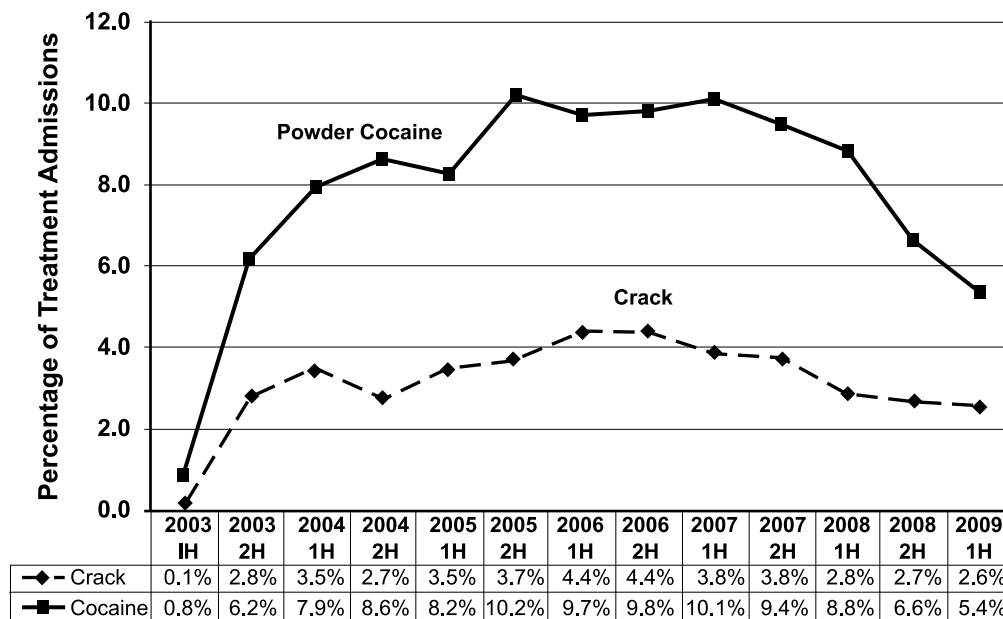


SOURCE: Philadelphia Adult Probation and Parole Department, as reported by Samuel Cutler at the January 2010 CEWG meeting

of such arrests decreased to 26 percent of arrests in 2009, down from a peak of 45 percent in 2007. Declines in proportions of primary treatment admissions were observed for both powder cocaine and crack, but they were especially marked for all cocaine admissions, from the first half of 2007 to the first half of 2009 (figure 2).

- The area representative from New York City reported that cocaine remained a major problem in New York City, but several indicators decreased in the first half of 2009, compared with 2007 and 2008, including treatment admissions and DAWN ED visits. Weighted ED data from DAWN showed a recent significant decrease in cocaine-involved visit reports in New York City from 2007 to 2008 (a decrease of 11 percent).
- In the southern region:
 - Cocaine continued its lead over all other drugs in abuse indicators in the Miami/
- The Baltimore and Washington, DC, area saw similar high levels of cocaine indicators, with continuing declines in indicators, including decreases in arrestees testing positive for cocaine and cocaine-related deaths.
- Cocaine indicators were reported as still high in Atlanta. The area representative reported that the long, slow decline in indicators noted in previous reporting periods may have stabilized in the first half of 2009.
- In general, declines in cocaine indicators were observed for the Midwest region, with the exception of Chicago, where cocaine indicators

Figure 2. Comparison of Primary Cocaine and Crack Admissions as a Percentage of Primary Treatment Admissions Excluding Primary Alcohol Admissions, Maine: 2003–1H 2009 in Half-Yearly Intervals



SOURCE: Maine Treatment Data System, as reported by Marcella Sorg at the January 2010 CEWG meeting

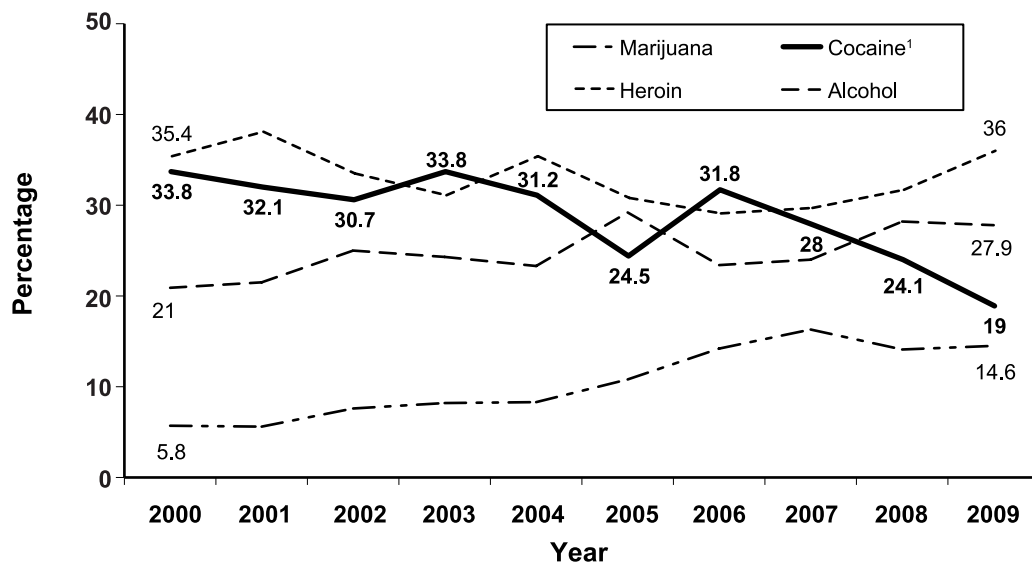
remained high and stable. The exception was weighted DAWN ED visits in 2008, which declined by 12 percent from 2006.

- Proportions of primary cocaine treatment admissions continued to show declines since 2006 in Detroit (figure 3). Weighted ED visit rates involving cocaine showed a significant decline (21 percent) in 2008 from both 2006 and 2007 (see appendix table 3.1).
- Although still a primary drug of abuse, area representatives from Cincinnati, Minneapolis/St. Paul, and St. Louis all reported declines in cocaine indicators. In Minneapolis/St. Paul, both treatment admissions and ED indicators were down in 2009 from previous years. Cocaine was the primary substance abuse problem for 6.4 percent of total treatment admissions in the first half of 2009 in the Minneapolis/St. Paul area, compared with 9.9 percent in 2008 and 11.6 percent in 2007. Both cocaine-related treatment admissions and deaths decreased in St. Louis in the

first half of 2009, and availability was down based on law enforcement reports. Cocaine treatment admissions in that area decreased by almost one-third over a 12-month period, from 1,235 in the first 6 months of 2008, to 825 in the first 6 months of 2009.

- Similarly, in the West, CEWG representatives from Denver, Los Angeles, Phoenix, San Diego, Seattle, and Texas reported declining indicators for cocaine in their areas.
 - In both the State of Colorado and the metropolitan Denver area, several cocaine indicators declined in 2009. Statewide, treatment admissions in Colorado had remained stable from 2002 to 2008 (between 18 and 22 percent of all admissions), but they dropped to 16 percent in the first half of 2009.
 - In San Diego, primary cocaine treatment admissions constituted 7 percent of all admissions in 2008, compared with 6 percent in the first half of 2009. Seized drug items identified in the first half of 2009

Figure 3. Percentage of Publicly Funded Primary Cocaine Treatment Admissions, Including Primary Alcohol Admissions, Compared With Admission for Selected Other Primary Drugs of Abuse, City of Detroit: Fiscal Years 2000–the First Half of 2009



¹Ninety-two percent of cocaine admissions are for crack cocaine.

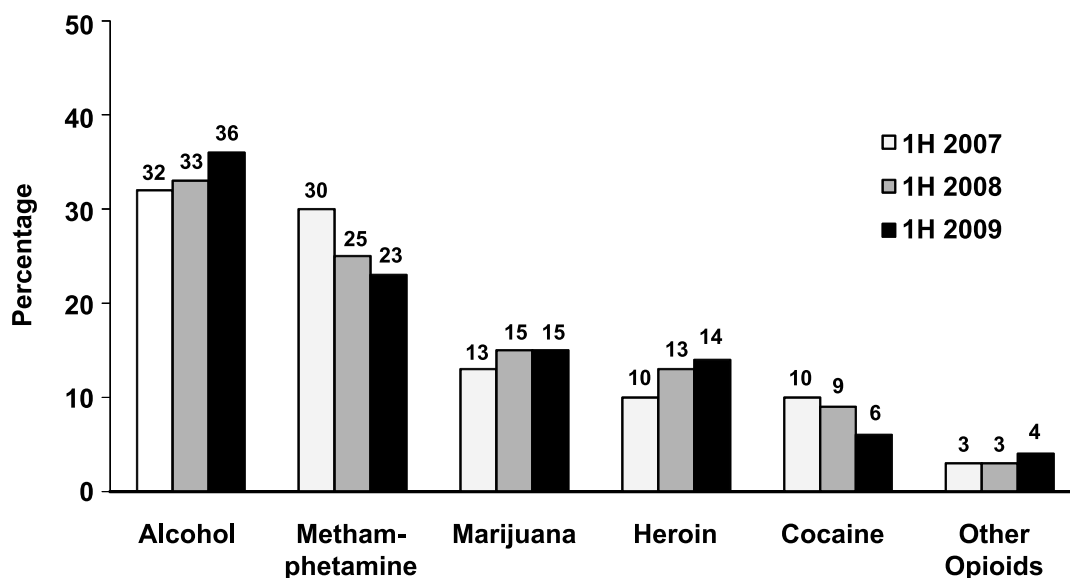
NOTE: 2009 treatment data are for the first half of the calendar year, January–June 2009.

SOURCE: Michigan Department of Community Health, as reported by Cynthia Arfken at the January 2010 CEWG meeting

testing positive for cocaine decreased to 10 percent in the first half of 2009, compared with 13 percent in 2008.

- Treatment admissions for cocaine were also down in Seattle, Texas, and Phoenix (Maricopa County) (figure 4). A decline in cocaine-related hospital admissions in the Phoenix area, reported in 2007 and 2008, continued in the first half of 2009.
- The San Francisco area representative reported mixed cocaine indicators. Treatment admissions continued to increase slightly in the first half of 2009 from the first half of 2008. However, weighted DAWN estimated ED visits in 2008 represented only 28.6 percent of all visits, compared with 35.2 percent in 2006; weighted DAWN ED visits declined by 28 percent from 2006 to 2008. Drug items seized and identified by NFLIS as containing cocaine for the San Francisco area for the first half of 2009 were also lower than in previous years.
- The Hawaii/Honolulu area was the one CEWG area for which an increase in cocaine indicators was reported by the area representative—reversing a multiyear downward trend. The area representative reported increases in both treatment admissions and cocaine-related deaths in the first half of 2009. Treatment admissions for cocaine in Hawaii totaled 295 for the first half of 2009, which if annualized would nearly double the number for the 12 months in 2008 ($n=316$).
- A shift in cocaine treatment admissions by gender was reported in Philadelphia, where females, who comprised 41 percent of admissions in 2001, represented only 28.2 percent by mid-2009. Also in Philadelphia, treatment admissions have shifted over the past 4 years to an older cohort, with more than 48 percent of admissions for cocaine older than 40 in the first half of 2009, compared with slightly more than 43 percent in 2007. The CEWG area representative from Los Angeles reported an increase in the proportion of African-Americans in cocaine treatment admissions in 2009 over the past 5 years, while the Texas area representative

Figure 4. Primary Cocaine and Selected Other Drug Treatment Admissions as a Percentage of Total Treatment Episodes, Maricopa County: 1H 2007–1H 2009



SOURCE: Arizona Department of Health Services, as reported by James Cunningham at the January 2010 CEWG meeting

reported a continuing decrease in African-American crack users from 1993 to 2009.

- A guest speaker from the DEA reported to the CEWG that a reduced supply of cocaine across the United States since 2007 has resulted in an increase in cocaine prices and a decrease in purity and availability, suggesting that disruptions in markets can affect use and abuse levels and patterns. However, availability can differ considerably between regions of the country. On the east coast, the New York City representative reported that street reports indicate wide availability in the city, although a decline in crack quality was noted. Ethnographic reports in Chicago in the midwestern region suggest that availability of powder cocaine has remained moderate in that city. In the West, while the quality of crack/cocaine may have declined, the price of cocaine in Los Angeles decreased in the first half of 2009, and anecdotal reports in Denver suggest a limited supply in that area.
- Several CEWG area representatives reported an increase in the use of adulterants with cocaine, and reports on the presence of levamisole in combination with cocaine continued across the CEWG areas. A guest speaker from SAMHSA's Center for Substance Abuse Treatment (CSAT) reported to the CEWG that the addition of pharmaceutical agents to cocaine first surfaced as a problem in 2004. Levamisole, used in veterinary medicine as an antiparasitic drug, is no longer an approved drug for use in humans (it was previously approved as a cancer medication). Negative effects from levamisole include agranulocytosis, a relatively uncommon condition in the United States, and severe neutropenia. As reported in the June 2009 CEWG meeting report, SAMHSA issued a public health alert in September 2009 about the risk that substantial levels of cocaine may be adulterated with levamisole. In 2005, less than 2 percent of seized cocaine samples analyzed in the DEA's System to Retrieve Information from Drug Evidence (STRIDE) contained levamisole; by 2009, 73 percent of the cocaine samples analyzed by the DEA contained levamisole.
- Several area representatives across all CEWG regions reported on levamisole. In Maine, 38 percent of cocaine samples seized and identified in 2009 contained levamisole, up from 2 percent in 2006. A recent study by the Washington, DC, Pretrial Services Agency found levamisole in 45 percent of randomly selected cocaine-positive specimens analyzed in that city. Levamisole and other adulterants were also reported in at least one-half of cocaine toxicology reports in both Miami/Dade and Ft. Lauderdale/Broward Counties. The Denver area representative reported that 66 percent of the cocaine exhibits analyzed in the Denver crime laboratory in the first half of 2009 contained levamisole, an increase over the 50 percent reported in 2008.
- The CEWG area representative from Detroit reported that levamisole continued to be detected in many decedents in that area (84 in just the first half of 2009, compared with 133 for 2008). In Cincinnati, cocaine and crack cocaine drug items seized and submitted for laboratory analysis revealed that 67 percent tested positive for levamisole. In Philadelphia, the percentage of deaths with the presence of both cocaine and levamisole rose from 10.9 percent in the first half of 2007 and 15.0 percent in the first half of 2008 to 53.6 percent in the first half of 2009, with a substantial jump noted between the first and second halves of 2008 (from 15.0 to approximately 46 percent) (figure 5).
- Treatment admissions data for the first half of 2009 revealed that primary cocaine treatment admissions, including primary alcohol admissions, did not rank first in frequency in any CEWG areas, but they ranked second in 1 of the 23 reporting CEWG areas: Miami/Dade County (table 2).
- Cocaine was the drug most frequently identified by forensic laboratories in 7 of 22 reporting CEWG areas—Atlanta, Denver, Maine, Miami, New York City, San Francisco, and Washington,

DC—in the first half of 2009 (table 1 and figure 21). Based on forensic laboratory analysis of drug items identified in the first half of 2009, cocaine/crack ranked first in three of the five areas in the southern region (Atlanta, Miami, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and two of eight areas in the western region (Denver and San Francisco). In none of the CEWG areas in the midwestern region did cocaine rank first. However, it ranked second in frequency of drug items identified in four of the five areas in the midwestern region (Chicago, Cincinnati, Detroit, and St. Louis) (table 1; appendix table 2).

- Based on weighted DAWN data, estimated numbers and rates of ED visits involving cocaine increased significantly in 4 of 11 CEWG reporting areas between 2004 and 2008, namely Boston, Denver, Detroit, and New York City. From 2007 to 2008, 5 of the 11 CEWG reporting areas had declines in weighted cocaine ED visits and visit rates: Boston, Denver, Detroit, New York

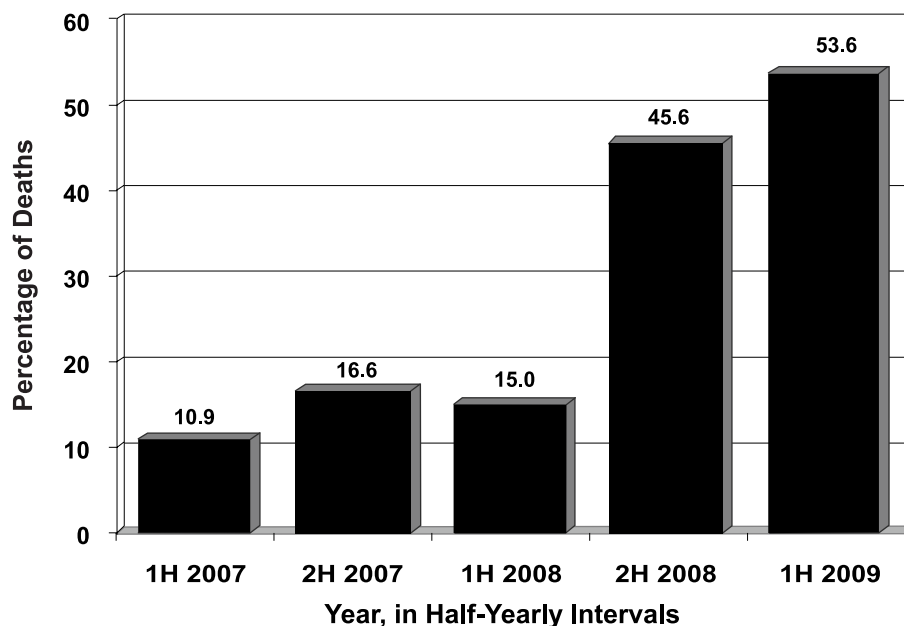
City, and Phoenix (section IV, figure 23; appendix table 3.1).

Heroin

- *Increases in heroin indicators, documented in the January and June 2009 CEWG meeting reports, were also observed in this reporting period. Ten CEWG areas from all four regions of the country reported increases in heroin indicators: Phoenix, San Francisco, and Texas in the West; Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis in the Midwest; Maryland in the South; and Boston in the East.*

- In Phoenix (Maricopa County), proportions of heroin treatment admissions increased in the first half of 2009 (when they were 14 percent of all admissions), compared with the first half of 2007 (10 percent); they were 13 percent in the first half of 2008. Heroin-related hospital admissions increased in the first half of 2009, and weighted DAWN ED visit data

Figure 5. Percentage of Deaths With the Presence of Cocaine Also Testing Positive for Levamisole, Philadelphia: 1H 2007 to 1H 2009, in Half-Yearly Intervals

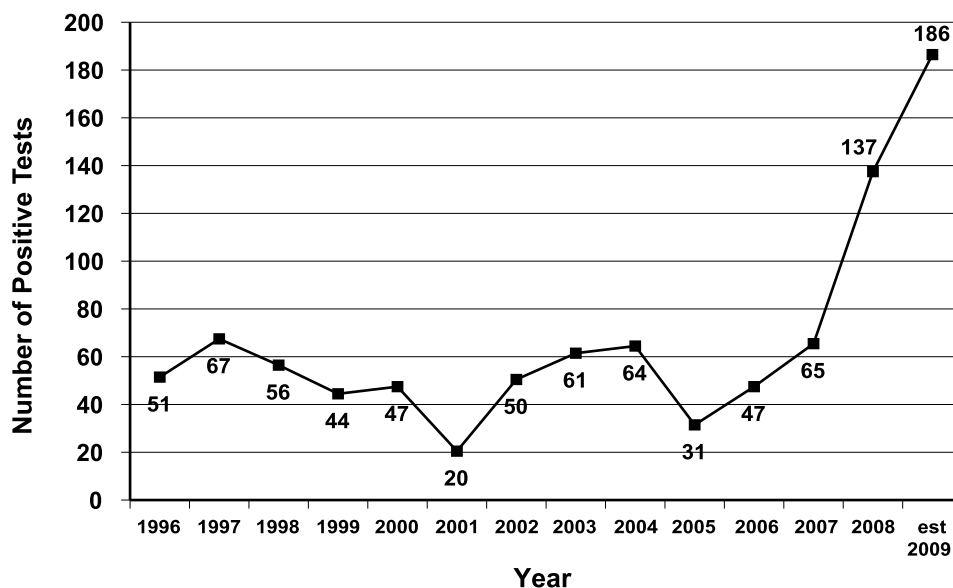


SOURCE: Philadelphia Medical Examiner's Office, as reported by Samuel Cutler at the January 2010 CEWG meeting

showed that estimated heroin-involved visits increased by 53 percent in the 5-year period, from 2004 to 2008.

- The San Francisco area representative reported a gradual increase in proportions of heroin treatment admissions from 2008 to the first half of 2009. However, weighted DAWN ED visits involving heroin decreased from 2006 to 2008 by 33 percent (rates per 100,000 population were 91.3 in 2008 and 114.1 in 2007, compared with 141.7 in 2004).
- In Texas, heroin-related treatment admissions as a percentage of all admissions were up from 11 percent in 2008 to 12.4 percent in 2009; calls to the poison control center were 208 in 2009, compared with 196 in 2008.
- Although still at a moderate level in Cincinnati, several heroin indicators increased in 2009 over previous years. The number of exposure cases involving heroin reported to poison control increased by 32 percent in 2009 over 2008. Of the drugs seized and identified by NFLIS in the first half of 2009, heroin comprised 9.6 percent of the total, an increase over 5.7 percent in 2008.
- Treatment admissions with heroin as the primary drug of abuse continued to increase in Detroit, where heroin ranked first among primary drug treatment admissions. Thirty-six percent of publicly funded admissions in FY 2009 were attributed to heroin, compared with 31.7 percent in fiscal year (FY) 2008. Deaths in the Detroit area involving heroin increased in the first half of 2009 over 2008, and calls to the poison control center about intentional use of heroin increased in the first half of 2009, compared with the first half of 2008.
- The gradual increase in heroin indicators in the Minneapolis/St. Paul area since 2000 was reported by the area representative as possibly stabilizing in the first half of 2009. Primary heroin-related treatment admissions for the first half of 2009 accounted for nearly the same proportion (6.5 percent) of all admissions as in 2008 (6.7 percent).

Figure 6. Number of Positive Toxicology Tests for Heroin in Medical Examiner Cases, St. Louis City and County: 1996–2009 (Based on Annualized Data for 1H 2009)



SOURCE: Medical Examiner's Office, St. Louis County, as reported by Heidi Israel at the January 2010 CEWG meeting

- The increase in heroin indicators was a major concern for law enforcement and health professionals in the St. Louis area, as reported by the area representative. Heroin-related treatment admissions in the St. Louis area increased by 14 percent from the first half of 2008 to the first half of 2009. Deaths attributed to heroin increased in both the City and County of St. Louis (figure 6). In addition, heroin represented 10 percent of drugs seized and identified by NFLIS in the first half of 2009, compared with 6.2 percent of drugs in 2007.
- Heroin indicators remained high in both Maryland and Washington, DC, particularly in the city of Baltimore (60 percent of primary heroin treatment admissions in Maryland were in Baltimore City); and twice as many drug items were seized and identified as heroin by NFLIS in Baltimore City, compared with Washington, DC, in the first half of 2009).
- The Boston area representative reported continuing high heroin indicators in that area, with several indicators slightly increasing in 2008 and the first half of 2009. Heroin continued to lead all treatment admissions as the primary drug in Boston in the first half of 2009, at 51 percent, which is the highest percentage of admissions in recent years. Heroin calls to the substance abuse hotline rose to 34 percent of all calls in FY 2009, compared with 31 percent in 2007 and 32 percent in 2008.
- Heroin indicators remained high, but with mixed (no consistent pattern of change noted), indicators in Chicago, New York City, and Philadelphia.
 - In Chicago, while several indicators were stable, weighted DAWN ED visits involving heroin showed a significant increase of 22 percent from 2007 to 2008. In 2008, 31 percent of total estimated ED visits for major substances of abuse involved heroin.
 - Heroin remained a major problem in New York City. More than one-quarter of all primary treatment admissions in the first half of 2009 were for heroin, although the number of primary heroin admissions declined slightly to the lowest number since 1999 (10,618 admissions in the first half of 2009, down from 11,688 admissions in the second half of 2008, and 12,059 in the first half of 2004, at its peak). Figure 7 shows that while the numbers of heroin treatment admissions to noncrisis services remained relatively stable in New York City from 2007 to 2008, they rose in the city's metropolitan suburbs, upstate metropolitan areas, and rural New York State, although from lower bases.
 - In Philadelphia, indicators continued to be high and stable, but a decline in proportions of primary heroin treatment admissions was reported in the first half of 2009 (14.5 percent, compared with 17 percent in 2008).
- Several CEWG areas reported stable and/or mixed indicators for heroin: Hawaii/Honolulu, Los Angeles, San Diego, Seattle, Miami, and Maine.
 - The Honolulu representative reported that primary treatment admissions for heroin may be increasing (based on annualized data) in Hawaii, with 94 admissions for the first half of 2009, compared with 162 for 2008. However, police arrests in Honolulu may be declining (based on annualization of 63 arrests in the first half of 2009, compared with 145 in 2008).
 - The Los Angeles area representative reported stable heroin indicators for the first half of 2009—treatment admissions, deaths with heroin detected, and drug items seized and identified as heroin. Primary heroin treatment admissions were also stable in the Seattle area, according to the area representative.
 - In San Diego, most indicators (proportions of drugs seized and identified as heroin, arrestees testing positive for heroin, and drug overdoses

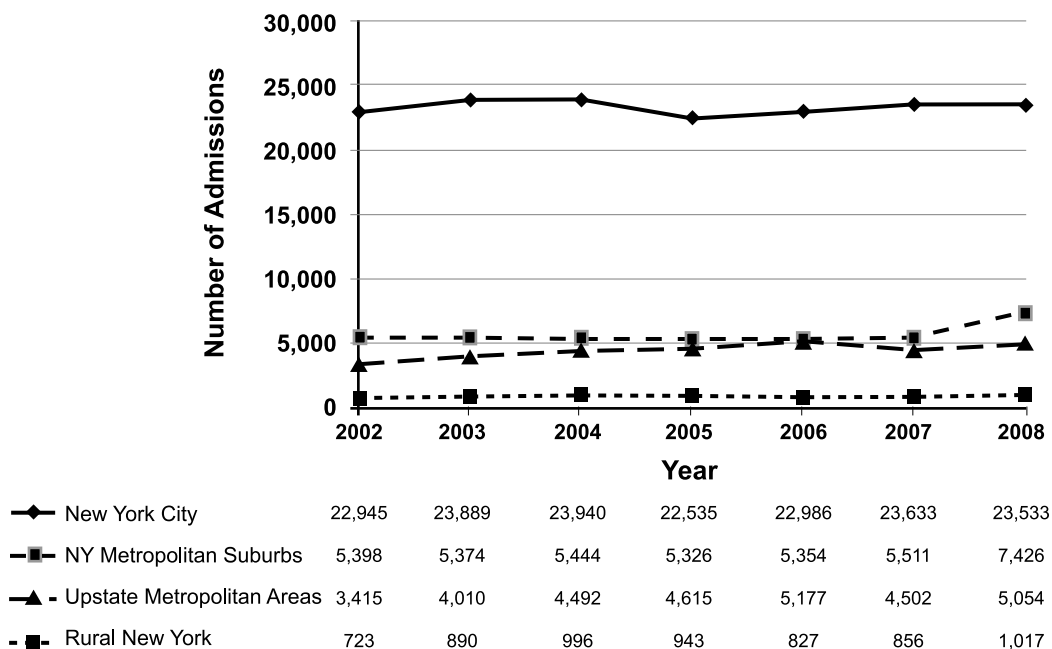
involving heroin) remained stable from previous reporting periods. However, primary heroin treatment admissions decreased by 4 percent from 2008 to 2009. In contrast, there was an increase of 65 percent in the estimated number of weighted DAWN ED visits involving heroin from 2007 to 2008.

- After showing modest increases in recent reporting periods, the Miami area representative reported stable indicators for heroin in the South Florida area. While heroin consequences were more prevalent in Miami/Dade County than Ft. Lauderdale/Broward County, numbers of deaths declined in both counties in the first half of 2009, compared with the previous 6 months.
- The Maine area representative reported that heroin indicators remained moderately high and mixed in the first half of 2009. Primary treatment admissions for heroin were down slightly; proportions of deaths declined by

1 percent from 2008; and arrests remained stable. Drugs seized and identified as heroin, however, continued a 3-year increase, from 7 percent in 2007, to 8 percent in 2008, and 15 percent in the first half of 2009.

- Although treatment admissions for heroin increased slightly both statewide for Colorado and for the Denver/Boulder metropolitan area in the first half of 2009, the area representative reported that heroin lagged far behind cocaine, marijuana/cannabis, and methamphetamine among drug items submitted for testing by law enforcement in the first half of 2009 in Arapahoe, Denver, and Jefferson Counties. After experiencing increases in several indicators in 2008, the Atlanta area representative reported low and stable indicators for heroin. Primary heroin treatment admissions, which were 4.9 percent in the first half of 2009, compared with 4.6 percent in 2008, were concentrated in the urban counties of the Atlanta area.

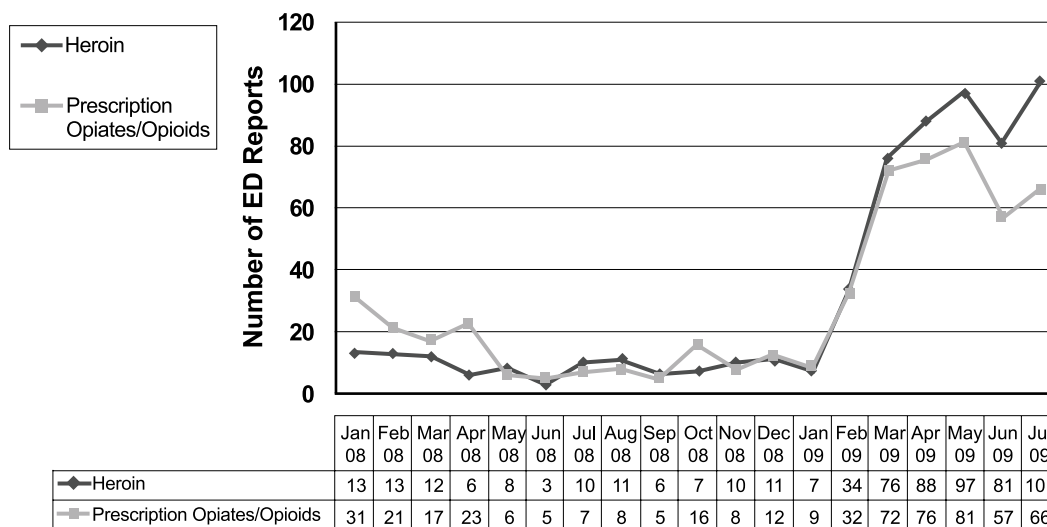
Figure 7. Number of Heroin Treatment Admissions to Noncrisis Services, by Region in New York State: 2002–2008



SOURCE: New York State Office of Alcoholism and Substance Abuse Services, as reported by Rozanne Marel at the January 2010 CEWG meeting

- The Miami area representative reported an emerging pattern in that area, documented by death data, of concurrent use of heroin and prescription opioids. Similarly, in a survey of 477 participants in syringe exchanges in Seattle in May, 2009, as reported by the area representative, approximately one-half of those surveyed reported concurrent use and abuse of heroin with cocaine and methamphetamine.
- Some area representatives noted a shift in heroin indicators from the metropolitan areas to surrounding suburban areas. Of particular concern in the New York City area, as reported by the area representative, was a substantial increase in heroin and other opiate indicators in the suburban area surrounding New York City. The CEWG area representative noted that DAWN *Live!* ED reports showed an increase in unweighted heroin and nonmedical prescription opiate/opioid ED reports in suburban New York (five suburban counties proximate to New York City) (figure 8), with a corresponding decrease in reports in New York City (the Five Boroughs) (figure 9). While monthly unweighted ED reports involving heroin and nonmedical use of pharmaceutical opiates declined from January 2008 to their lowest level in July 2009 in New York City, such reports rose over the period in suburban New York counties to their highest level in July 2009 (figures 8 and 9).
- According to the St. Louis area representative, heroin-related deaths were reported in most of the rural counties surrounding St. Louis. This possible shift in heroin use and abuse from urban centers to surrounding suburban areas was also a potential dynamic in the Chicago area, as noted by the area representative. In the first quarter of 2009, four suburban counties in the Chicago area reported an increase in deaths due to suspected heroin overdoses, while Cook County showed no increase.
- An increase in young, White heroin users in 2008, described in the June 2009 CEWG report, was reported in the first half of 2009 by the San Diego and Detroit representatives. In San Diego, proportions of primary treatment admissions for heroin have increased among White clients and younger clients between the first halves of 2005 and 2009. In Detroit, comparisons of FY 2008 and FY 2009 data showed that White heroin treatment clients continued to have a younger mean age, and were more likely to inject, than African-American clients (37.6 versus 50.8 years, and 71.4 versus 33.6 percent, respectively).
- Injection continued to be the primary mode of administration of the heroin reported among primary treatment admissions in the first half of 2009 in most CEWG areas. In New York City, the percentage of injectors among primary heroin treatment admissions in the first half of 2009 rose to 40 percent (from 39 percent in 2008). This was the first semiannual period it has reached 40 percent since 1997. However, the San Diego area representative reported an increase in smoking among primary heroin treatment admissions between the first halves of 2005 and 2009 (21 percent smoked in 2009, compared with 11 percent in 2005; 74 percent preferred injection in 2009, compared with 83 percent in 2005). In Chicago, “snorting” (inhaling) remained the primary route of heroin admission for clients entering treatment.
- South American and Mexican heroin continue to dominate the U.S. heroin market, according to the guest speaker from the DEA. The eastern United States market is primarily South American heroin, while the predominant heroin in the western States is Mexican. Some westward movement of South American heroin has been detected, and the St. Louis area representative reported a growing, competitive, and mixed market, with both Mexican black tar and South American heroin available in that area. While the primary form of heroin consumed in Arizona remained black tar, law enforcement seizures suggested that Phoenix continued to serve as a feeder city for white heroin arriving from Mexico. HDMP information indicates that Mexican brown powder heroin is also becoming more common in the United States (figure 10).
- Several indicators point to an increase in the trafficking and distribution of Mexican heroin in the United States, including the increase in heroin prevalence indicators reported in

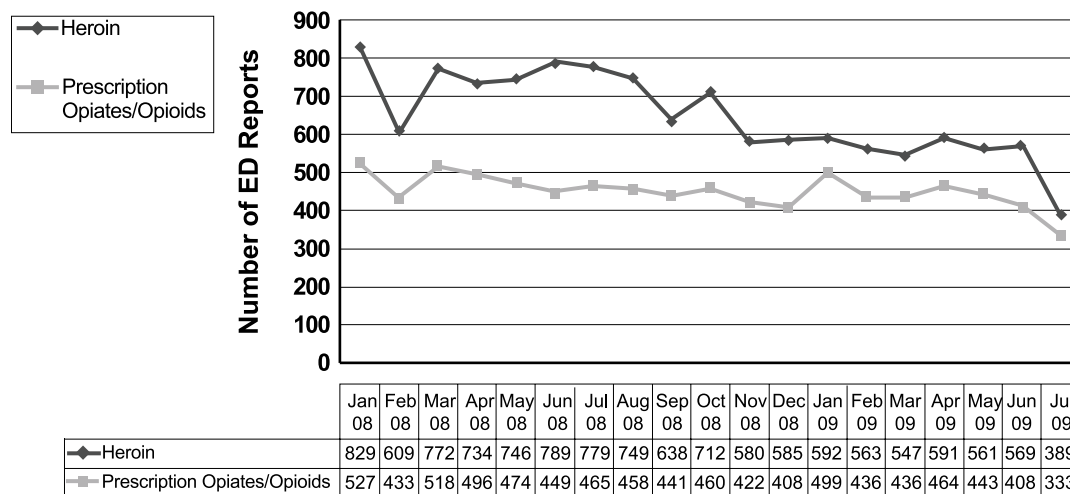
Figure 8. Number of Monthly Unweighted Heroin and Nonmedical Prescription Opiate/Opioid-Involved Emergency Department Reports from DAWN Live!¹ in Suburban New York: January 2008–July 2009



¹The unweighted data are from hospitals in five counties: Nassau, Suffolk, Westchester, Rockland, and Putnam reporting to DAWN Live! January 2008 to July 2009. All DAWN cases are reviewed for quality control. Based on this review, cases may be corrected or deleted, and therefore, are subject to change. Updated 8/26/2009.

SOURCE: DAWN Live!, OAS, SAMHSA, as reported by Rozanne Marel at the January 2010 CEWG meeting

Figure 9. Number of Monthly Unweighted Heroin and Nonmedical Prescription Opiate/Opioid-Involved Emergency Department Reports from DAWN Live!¹ in New York City: January 2008–July 2009



¹The unweighted data are from hospitals in the Five Boroughs of New York City: The Bronx, Brooklyn, Manhattan, Queens, and Staten Island reporting to DAWN Live! January 2008 to July 2009. All DAWN cases are reviewed for quality control. Based on this review, cases may be corrected or deleted, and therefore, are subject to change. Updated 8/26/2009.

SOURCE: DAWN Live!, OAS, SAMHSA, as reported by Rozanne Marel at the January 2010 CEWG meeting

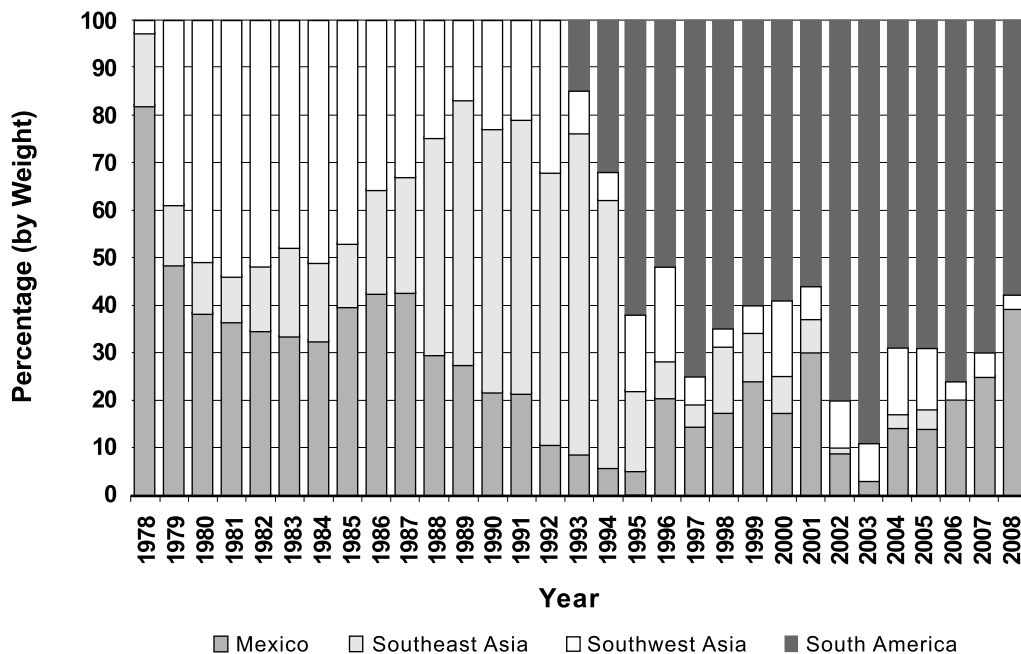
several CEWG areas in the first half of 2009. Mexico has increased poppy cultivation and heroin production, and larger quantities of heroin are being seized at the United States–Mexico border. South American heroin is also smuggled across the southwest U.S. border, and an increasing involvement of Mexican Drug Trafficking Organizations (DTOs) in trafficking South American heroin has been noted in recent years.

- Across the country, purity of South American heroin remained relatively stable from 2005 to 2008, according to the HDMP, while Mexican heroin purity declined slightly during that period.
- In Chicago, the average percent purity per milligram of heroin, as reported by the DEA, increased to 23.8 percent in 2008, its highest level since 1999. However, some CEWG areas reported increasing problems with heroin adulteration. The Cincinnati area representative reported that 13 percent of heroin exposures reported to poison control were

suspected to be adulterated with clenbuterol (due to symptoms reported during admission).

- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore (approximately 51 percent) and Boston (approximately 50 percent) in the first half of 2009 (section IV, table 4). In Baltimore, Boston, Chicago, Detroit, and San Francisco, heroin was the substance most frequently reported as the primary problem at treatment admission in the reporting period (table 2; appendix table 1).
- In 11 of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in the first half of 2009. Proportions were highest in Baltimore and Maryland (approximately 25 and 20 percent, respectively). They were lowest in Atlanta, Honolulu, and Minneapolis/St. Paul, at approximately 1–2 percent of drug items identified in each area (section IV, figure 21; appendix

Figure 10. Changes in Percentages of Heroin (by Weight) Analyzed Through the DEA Heroin Signature Program (HSP) from Sources in Mexico, Southeast Asia, Southwest Asia, and South America: 1978–2008



SOURCE: DEA Heroin Signature Program (HSP), as reported by Scott Rowan at the January 2010 CEWG meeting

table 2). Heroin was not ranked first in drug items seized in any CEWG area, although it was ranked second in one area—Maine (table 1).

- Statistically significant changes in weighted DAWN ED visits and rates in 2008 compared with 2004 were noted for 4 of 11 reporting CEWG areas. These changes consisted of increased estimated ED visits involving heroin in Denver, Detroit, and Phoenix, and decreased visits in San Francisco (section IV, figure 25; appendix table 3.2).
- Data from the HDMP suggest that for CY 2008, South American heroin continued to be the primary source of heroin east of the Mississippi River, as has been the case since the mid-1990s. Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi. Average purity levels for South American heroin increased in 4 of 10 CEWG areas (Atlanta, Chicago, Miami, and Baltimore) from 2007 to 2008. They remained stable in one area, Boston, and declined in five other areas—Detroit, New York City, Philadelphia, St. Louis, and Washington, DC. Average prices for South American heroin fell in 6 of 10 CEWG areas (Atlanta, Baltimore, Chicago, Detroit, New York City, and Philadelphia) and rose in 4 (Boston, Miami, St. Louis, and Washington, DC) (section IV, table 5). From 2007 to 2008, Mexican heroin average purity declined in 7 of 11 CEWG areas, namely Dallas, Houston, Los Angeles, Minneapolis, San Diego, San Francisco, and Seattle, while average purity increased slightly in 3 areas (El Paso, Phoenix, and San Antonio), and remained relatively constant in 1 area (Denver). The average price was lower or the same in 2008, compared with 2007, in 6 of 11 reporting CEWG reporting areas (Dallas, Denver, Minneapolis, Phoenix, San Antonio, and San Francisco), and was higher in 5 areas (El Paso, Houston, Los Angeles, San Diego, and Seattle) (section IV, table 6).

Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

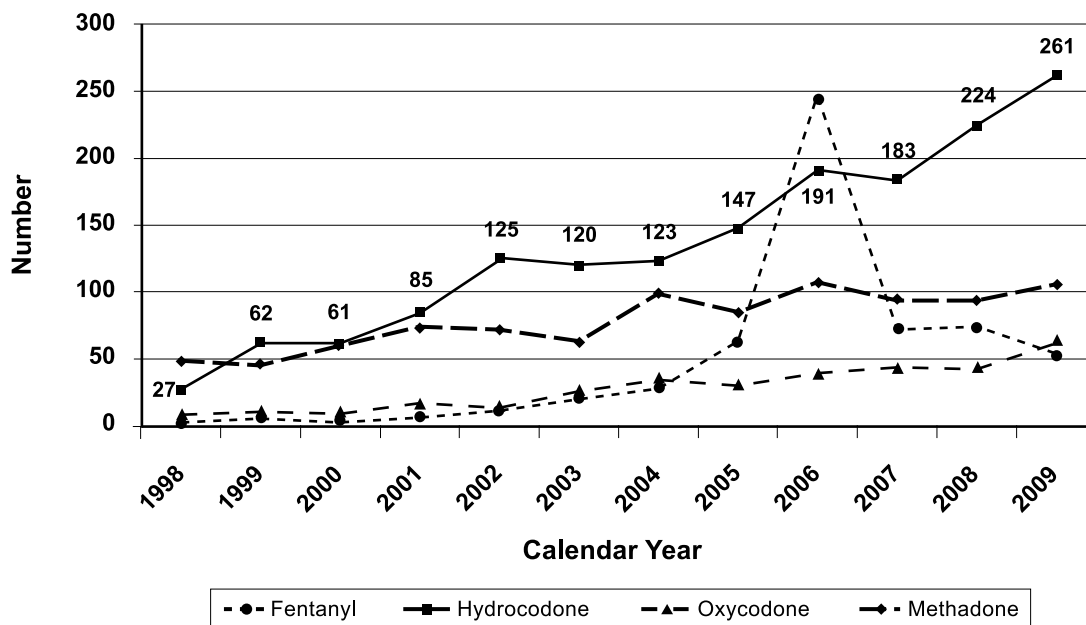
- *The increasing prevalence of indicators for opiates/opioids other than heroin reported at recent*

CEWG meetings continued across regions and across most CEWG areas in 2009.

- In the West, Denver, Honolulu, Los Angeles, Phoenix, San Francisco, Seattle, and Texas showed increases in other opiate/opioid indicators over previous reporting periods. The San Diego area representative reported that indicators for narcotic analgesics were low and remained stable.
 - In the Denver metropolitan area, increases were noted in prescription opioid drugs seized and identified by NFLIS, treatment admissions data, and hospital discharge data, according to the area representative. In that CEWG area, treatment admissions for opioids other than heroin climbed from 4.5 percent of total admissions in the first half of 2007 to 7.8 percent in the first half of 2009, and the weighted DAWN ED visit rate involving narcotic analgesics increased from 87.5 per 100,000 population in 2007 to 104.4 per 100,000 in 2008, a significant increase of 22 percent.
 - In Phoenix, weighted DAWN ED visits for hydrocodone also increased significantly by 37 percent in 2008 over 2007 (data not shown).
 - The San Francisco and Los Angeles area representatives reported that proportions of drug items seized and identified by NFLIS as containing oxycodone and hydrocodone in those areas increased slightly in the first half of 2009, compared with 2008.
 - Also in Los Angeles, reports of narcotic analgesics identified in coroner toxicology cases increased, from 24.5 percent of all cases in 2008 to 30.8 percent of cases in 2009 (January–October 2009). ARCOS data for Los Angeles also showed increases in opioid dosage unit sales to retail registrants between 2007 and 2008 of approximately 28 percent for buprenorphine, 9 percent for both methadone and morphine, 13 percent for oxycodone, and close to 2 percent for hydrocodone.

- In Seattle, where the most common pharmaceutical opioids continued to be methadone and oxycodone, the number and proportion of pharmaceutical opioid treatment admissions continued the steady increase from 1999 to the first half of 2009.
- Stable or increasing indicators for opiates/opioids were reported by all area representatives in the midwestern region of the country: Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis.
 - In Detroit, where most indicators were described as stable overall, reported deaths in 2009 involving the laboratory-confirmed presence of hydrocodone increased from 2008 numbers, with estimated 2009 oxycodone, methadone, and fentanyl deaths also increasing, although at lower levels, compared with 2008 (figure 11). The Detroit area representative also noted an increasing number of cases reported to the poison control center of “Trinity” or “Holy Trinity,” a combination of an opiate/opioid, Soma®, and a benzodiazepine, usually Xanax® (18 cases in the first 6 months of 2009).
 - The Minneapolis/St. Paul area representative reported an increasing number of American Indian/Native American clients admitted to addiction treatment programs with prescription opiates/opioids identified as the primary substance of abuse. While American Indians/Native Americans made up from 0.5 to 1.2 percent of the total population in the five counties of the Twin Cities metropolitan area (based on 2008 Census estimates), they comprised 13 percent of the admissions for other opiates in the first half of 2009 (this represents a nearly threefold increase from 4.5 percent of total admissions for other opiates in 2008). Illustrating other demographic changes in opioid indicators, figure 12 shows declines

Figure 11. Number of Deaths With Laboratory-Confirmed Presence of Hydrocodone, Compared With Selected Other Opioids (Oxycodone, Fentanyl, and Methadone), Wayne County, Michigan: 1998–2009¹



¹Data are for calendar years (1H 2009 data presented at the January 2010 CEWG meeting by the Detroit area representative were corrected and updated for this report).

SOURCE: Wayne County Medical Examiner Office, as reported by Cynthia Arfken at the January 2010 meeting

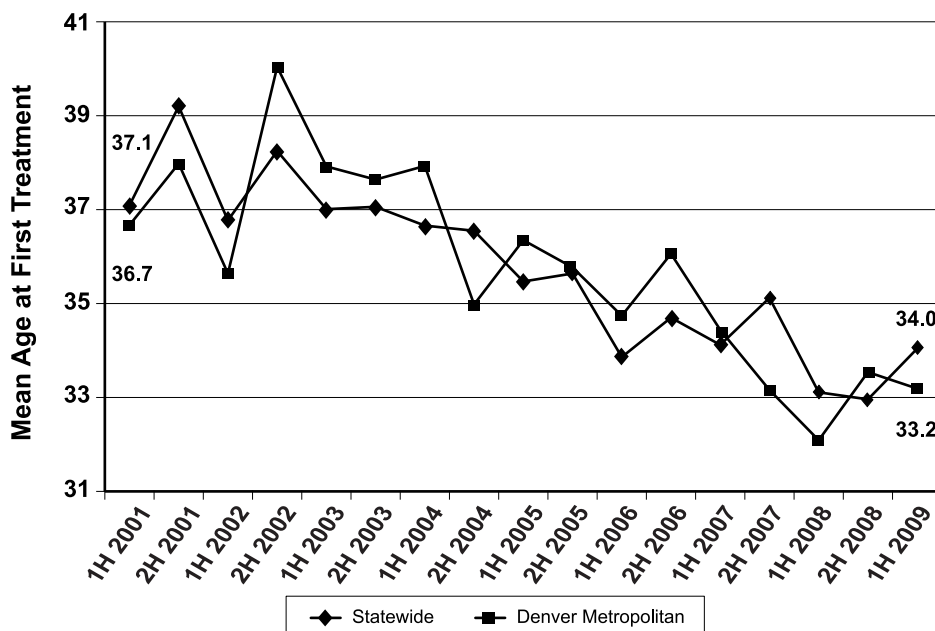
in the mean age at first treatment and the mean age of onset among treatment admissions with a primary opiate/opioid problem from 2001–2009 in Denver and Colorado as a whole.

- In the South, consequences associated with prescription-type opioids continued to be high in the South Florida area, particularly in Ft. Lauderdale/Broward County. The local area representative reported that indicators in that area suggest a newly emerging pattern of concurrent and sequential use of heroin and prescription opioids, rather than a progression from or to heroin. Oxycodone continued as the most frequently cited prescription opioid observed in most indicators in Miami/Dade County and Ft. Lauderdale/Broward County. Although still small in numbers, primary treatment admissions in Atlanta increased for oxycodone, and the number of drug items seized and identified by NFLIS as containing oxycodone and hydrocodone increased in the

first half of 2009, compared with the first half of 2008 (oxycodone was up from 145 to 230 in those respective periods; hydrocodone was up from 192 to 241).

- Area representatives in the Northeast reported moderate levels and increasing indicators in Boston; moderate and mixed indicators in Philadelphia (depending on the drug); low but increasing indicators in New York City; and high levels with mixed indicators for Maine.
 - In Boston, the proportion of other opioid helpline calls increased from 14 percent in FY 2008 to 17 percent in FY 2009, and the number of primary opiate/opioid treatment admissions increased in FY 2009 to 851, the highest number in more than 10 years (from FYs 2006 to 2008, the numbers were approximately 650 to 660).
 - Weighted DAWN ED visits involving the opiates/opioids category for New York City

Figure 12. Median Age at First Treatment Among Treatment Admissions With Primary Problems With Opiates/Opioids Other Than Heroin, Colorado and Denver: 2001–2009 in Half-Yearly Intervals



SOURCE: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health (DBH), Colorado Department of Human Services (CDHS), as reported by Kristen Dixon at the January 2010 CEWG meeting

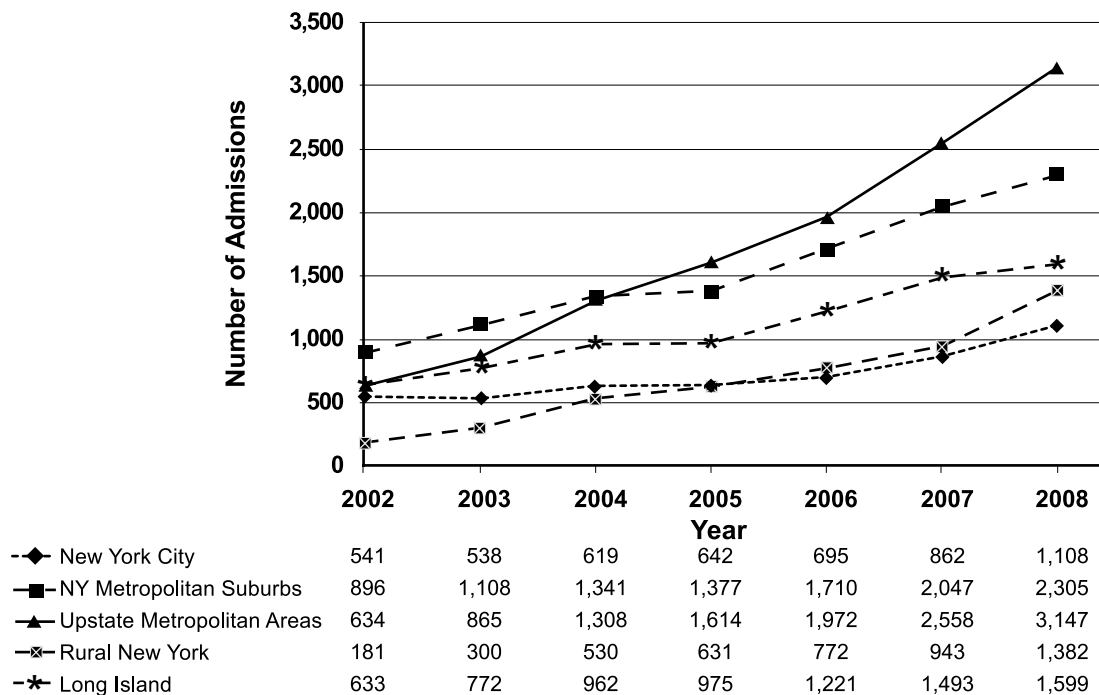
showed a significant 121-percent increase from 2004 (3,615 visits) to 2008 (7,984 visits), with significant increases of 237, 50, and 98 percent, respectively, for oxycodone, hydrocodone, and methadone over the period (significant increases were also observed for 2007–2008 for oxycodone and methadone). DAWN Live! data also showed that ED reports were increasing in suburban areas around New York City (figures 8 and 9). Proportions of primary treatment admissions for other opiates also increased in New York City, although as with heroin admissions (figure 7), these admissions also increased in the New York City suburban areas, Long Island, upstate metropolitan areas, and rural areas of New York State (figure 13).

- Treatment admissions for prescription narcotics were also up in Maine, where, at 56 percent, they comprised a majority of all

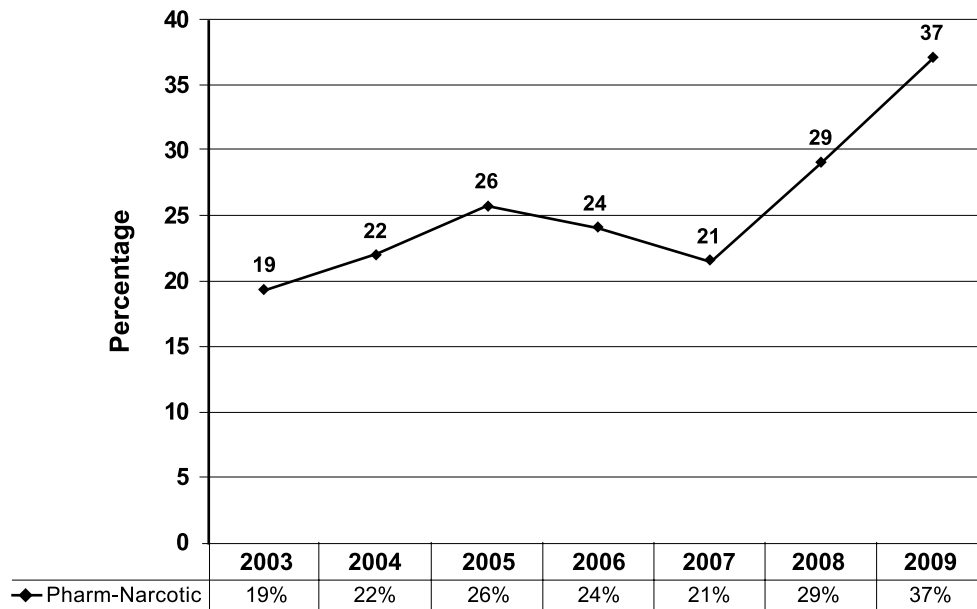
admissions for the first half of 2009. Arrests for offenses involving pharmaceutical narcotics also increased from 21 percent in 2007 to 37 percent in 2009 (figure 14).

- Although hydrocodone, oxycodone, and methadone continued to be the most reported narcotic analgesics abused across all CEWG areas, concern about the nonprescribed use of buprenorphine continued in several areas.
 - Buprenorphine-caused deaths were recorded in Maine in 2008 and the first half of 2009 (three in 2008 and one in 2009).
 - Poison control calls identified as buprenorphine in Cincinnati totaled 402 in 2009, compared with 21 in 2004.
 - The Chicago area representative reported that buprenorphine abuse continued in that area as a means to avoid withdrawal or to

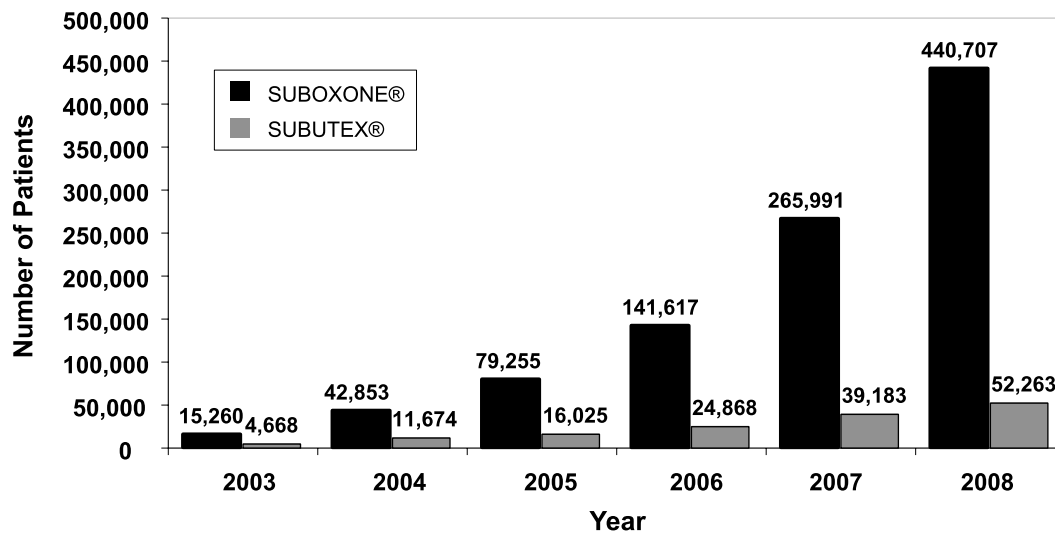
Figure 13. Number of Other Opiate Treatment Admissions to Noncrisis Services, by Region in New York State: 2002–2008



SOURCE: New York State Office of Alcoholism and Substance Abuse Services, as reported by Rozanne Marel at the January 2010 CEWG meeting

Figure 14. Percentage of Arrests for Pharmaceutical Narcotics, Maine: 2003–2009

SOURCE: Maine Drug Enforcement Administration, as reported by Marcella Sorg at the January 2010 CEWG meeting

Figure 15. Total Number of Patients Receiving a Prescription for Subutex® or Suboxone® from U.S. Outpatient Retail Pharmacies: 2003–2008

SOURCE: CSAT, SAMHSA, SDI (a health care analytics organization with headquarters in Plymouth Meeting, PA); Total Patient Tracker, extracted as of 3/09, as reported by Nicholas Reuter at the January 2010 CEWG meeting

- better manage an addiction to heroin, based on ethnographic studies.
- The Philadelphia area representative reported that Suboxone® was being used on the street to “get off heroin,” according to focus group findings in the fall of 2009.
 - The representative from SAMHSA’s CSAT reported on the increase in buprenorphine prescriptions dispensed by U.S. pharmacies, from 2003 to 2008 (figure 15), along with an increase in buprenorphine diversion across the Nation.
 - The area representative from the Baltimore/Maryland/Washington, DC, area corroborated this, with results from a recent study by the Center for Substance Abuse Research at the University of Maryland showing an increase in retail distribution of buprenorphine (Suboxone®) in Baltimore City and Baltimore County from 2007 to 2008.
- Of the 12 CEWG areas for which area representatives reported data on buprenorphine, increased indicators were noted in 6 areas, namely Maine, Washington, DC, Baltimore, Chicago, Cincinnati, and Detroit.
 - In the first half of 2009, treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 1 to approximately 9 percent in 19 of 20 reporting CEWG areas. The outlier was Maine, where nearly 32 percent of primary treatment admissions were for other opiate problems (table 7; appendix table 1). While none of the 20 CEWG reporting areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, other opiates ranked second in Maine, and third in Minneapolis/St. Paul (table 2).
 - Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in the first half of 2009. In Boston, Cincinnati, Maine, Maryland, and Philadelphia, oxycodone ranked fourth in drug items identified, and it ranked fifth in five other CEWG areas—Atlanta, Baltimore, New York City, Phoenix, and Seattle (table 1). Hydrocodone ranked fourth in drug items identified in Atlanta and Detroit and fifth in Cincinnati and Texas (table 1; section IV, table 8).
 - Buprenorphine ranked fourth in identified NFLIS drug items in Baltimore, fifth in Boston and Maryland, seventh in Maine and Seattle, and ninth in Washington, DC, in the first half of 2009 (table 1; section IV, table 8).
 - Methadone ranked in the top 10 identified drugs in New York City (7th); San Francisco (8th); Baltimore, Cincinnati, Honolulu, Maine, and Maryland (9th each); and Boston (10th) during this reporting period (table 1; section IV, table 8).
 - Between 2004 and 2008, estimated ED visits involving nonmedical use of opiate/opioid drugs other than heroin increased significantly in all 11 CEWG DAWN reporting areas (section IV, figure 27; appendix table 3.3).

Benzodiazepines/Depressants

- *Alprazolam and clonazepam continued to be the most frequently reported benzodiazepines in the indicator data in the first half of 2009 across the CEWG areas and regions.*
- Most of the CEWG area representatives who reported on benzodiazepines reported moderate levels with mixed or stable indicators (Los Angeles in the West; Detroit in the Midwest; Atlanta and South Florida in the South; and Philadelphia and Maine in the Northeast).
- However, increasing indicators were evident in areas across the western, midwestern, and north-eastern regions.
 - In the West, deaths in Seattle with benzodiazepines present increased in the first half of 2009 over 2007 and 2008. The Denver area representative reported a significant increase

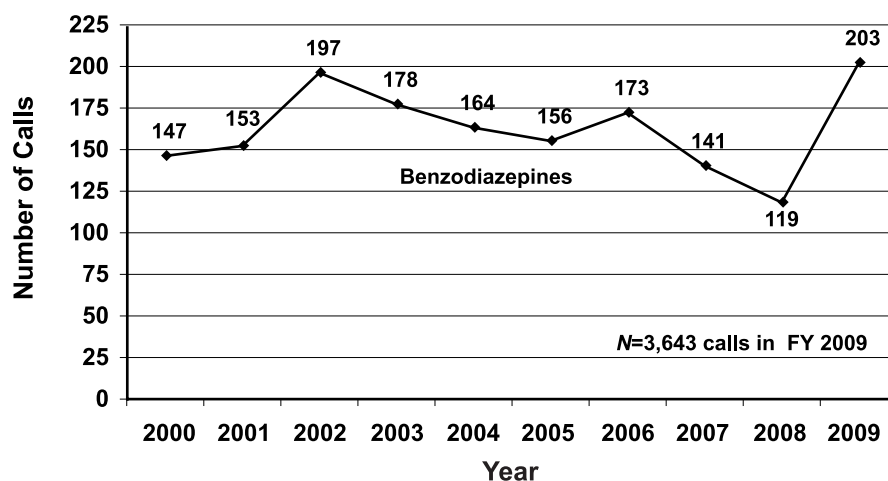
of 30 percent in weighted DAWN ED benzodiazepine-involved visits in the Denver metropolitan area from 2006 to 2008.

- In the midwestern region, the Chicago area representative reported a 34-percent increase in weighted DAWN ED visits involving benzodiazepines from 2004 to 2008 and a 19-percent increase from 2007 to 2008. In Cincinnati, the area representative reported that the most desirable benzodiazepines continued to be alprazolam, according to both users and law enforcement personnel. Counterfeit alprazolam (containing phenazepam and diazepam) was seized in the Cincinnati area for the first time in September 2009. Treatment admissions for benzodiazepines increased by two-thirds in St. Louis from the first half of 2008 ($n=25$) to the first half of 2009 ($n=42$). According to anecdotal reports from rural police, abuse was growing in rural areas around St. Louis.
- In Boston, in the northeastern region, the proportion of benzodiazepine calls to the helpline increased from 4 to 6 percent from FY

2008 to FY 2009 (figure 16), and weighted DAWN ED visits involving benzodiazepines increased by 30 percent from 2006 to 2008. In New York City, weighted DAWN ED visits for alprazolam increased by 79 percent from 2004 to 2008. The Maine area representative reported that although they constituted only 2 percent of both drug items seized and identified and arrests, benzodiazepines were implicated in a record number of 35 percent of drug-induced deaths in the State in the first half of 2009 (up from 24 percent in 2008).

- Atlanta and Texas had the highest percentages of alprazolam drug items identified in forensic laboratories in the first half of 2009, at 4.5 and 4.3 percent, respectively (section IV, table 9). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Atlanta; fourth in three CEWG areas (Miami, New York City, and Texas; fifth in Philadelphia; and sixth in Baltimore, Maryland, and Detroit) (table 1).
- Drug items containing clonazepam accounted for 2.2 percent of all drug items in Boston, where

Figure 16. Number of Helpline Calls Involving Drug Mentions of Benzodiazepines, Greater Boston¹: FY 2002–FY 2009²



¹Greater Boston includes Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19).

²FY 2009 runs from July 1, 2008–June 30, 2009.

SOURCE: Massachusetts Substance Abuse Information and Education Helpline; Graphics: Boston Public Health Commission Research and Evaluation Office (B5/70), as reported by Daniel Dooley at the January 2010 CEWG meeting

clonazepam figured as the sixth most frequently identified drug in forensic laboratories in the first half of 2009 (table 1; section IV, table 9).

- Diazepam ranked 8th in Cincinnati and 10th in Philadelphia, Detroit, and San Diego among drug items identified in NFLIS forensic laboratories in the first half of 2009 (table 1).
- Estimated ED visits involving nonmedical use of benzodiazepines increased significantly in 7 of the 11 reporting DAWN CEWG areas from 2004 to 2008. These were Boston, Chicago, Denver, Detroit, Minneapolis/St. Paul, New York City, and Phoenix. Significant increases in estimated ED visits and visit rates involving benzodiazepines in the 1-year period from 2007 to 2008 were experienced in five areas: Chicago, Detroit, Phoenix, San Diego, and San Francisco (section IV, figure 28; appendix table 3.4).

Methamphetamine

- *While methamphetamine continued to be a drug more predominant in the West than any other region, declining methamphetamine indicators in several western CEWG areas (San Diego, Denver, Phoenix, and San Francisco), reported in 2008, continued into the first half of 2009.*

- In San Diego, declines were reported by the area representative in proportions of primary methamphetamine drug treatment admissions in the first half of 2009, compared with the corresponding months in 2008, and in percentages of male and female adult arrestees testing positive for methamphetamine in 2008, compared with 2007. Numbers of drug overdose deaths involving amphetamine and methamphetamine also declined from 98 in 2007 to 83 in 2008. Weighted DAWN ED visits involving methamphetamine decreased by 29 percent, from 2006 (2,297 visits) to 2008 (1,625).
- The Denver area representative reported stable and slightly declining indicators for methamphetamine, although it also remained a major drug of concern in that area. Both

primary methamphetamine treatment admissions and hospital discharge reports for general stimulants, mostly methamphetamine, declined in the first half of 2009 from 2008 levels, and weighted DAWN ED visits involving methamphetamine decreased by 27 percent in 2008 from 2007, and by 36 percent from 2006 to 2008.

- Although methamphetamine was the illicit drug reported most often in Phoenix among primary treatment admissions, the area representative noted continued declining and stable indicators. Weighted DAWN ED visits involving methamphetamine declined by 36 percent from 2006 to 2008, but hospital admissions (related to methamphetamine/amphetamines), which had declined sharply in 2007, remained flat in 2008 and the first half of 2009.
- The San Francisco area representative similarly reported slowly declining methamphetamine indicators for the first half of 2009. Primary methamphetamine treatment admissions declined slightly in the first half of 2009 from 2008, and weighted DAWN ED visits and rates per 100,000 population declined by a significant 31 percent in 2008 from 2006.
- In Los Angeles, the area representative reported high but mixed and mostly stable indicators for methamphetamine. She also reported a possible leveling off of proportions of drug items containing methamphetamine identified in the first half of 2009, compared with 2008. A decline in the percentage of positive toxicology tests among decedents examined by the Los Angeles coroner from 2008 to the first half of 2009 was also reported (figure 17).
- Methamphetamine indicators continued to be moderate, although mixed, in Seattle, according to the area representative. Primary methamphetamine treatment admissions in King County have been steady since 2005. However, mortality data for the State of

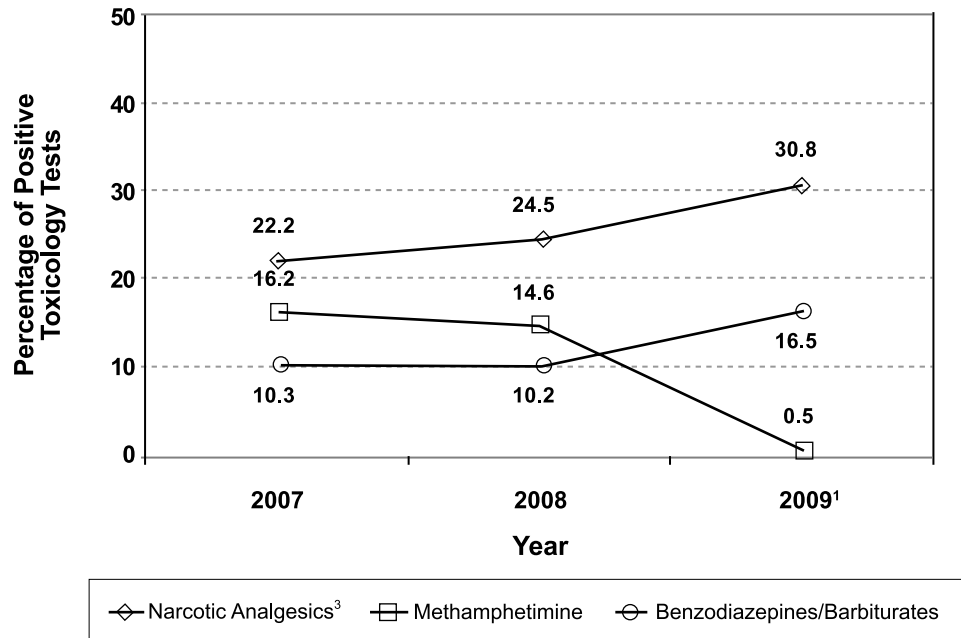
Washington showed an increase (from 178 in 2008 to 209 in 2009) in the number of deaths with methamphetamine detected, many of which were not ruled as drug-caused.

- Indicators in Texas remained high and stable, with the area representative reporting an increase in injecting, with an accompanying decrease in smoking, as a preferred route of administration.
- Only one area, Hawaii, reported an increase in methamphetamine indicators in the first half of 2009, reversing declines reported in 2008. According to the area representative, primary methamphetamine treatment admissions increased—1,992 such admissions were reported in the first half of 2009 (annualized to approximately 4,000), compared

with 2,726 in 2008. Police arrests involving methamphetamine in Honolulu also continued to be high.

- In the midwestern region of the country, methamphetamine continued to be a drug of concern in both the Minneapolis/St. Paul and St. Louis areas, where indicators were reported as mixed.
 - Although some indicators declined in the first half of 2009, methamphetamine treatment admissions and seizures of methamphetamine drug items by law enforcement in the Minneapolis/St. Paul area increased slightly in the first half of 2009 over previous reporting periods.
 - Primary methamphetamine treatment admissions decreased in the St. Louis area from the

Figure 17. Percentage of Positive Methamphetamine and Other Selected Drug Toxicology Cases Among Decedents Examined by the County Coroner, Los Angeles: October 2007–October 2009^{1,2}



¹2009 data are for January–October ($n=1,731$ toxicology cases).

²The percentage is taken on the total number of decedent cases for which alcohol and other drug (AOD) toxicology testing was done. Cases may have more than one drug detected within a category.

³The category, narcotic analgesics other than heroin/morphine, includes codeine, hydrocodone, hydromorphone, oxycodone, oxymorphone, methadone, and other narcotics.

SOURCE: Los Angeles County Coroner's Office (source of data for analysis of 2007–2009 data), as reported by Mary-Lynn Brecht at the January 2010 CEWG meeting

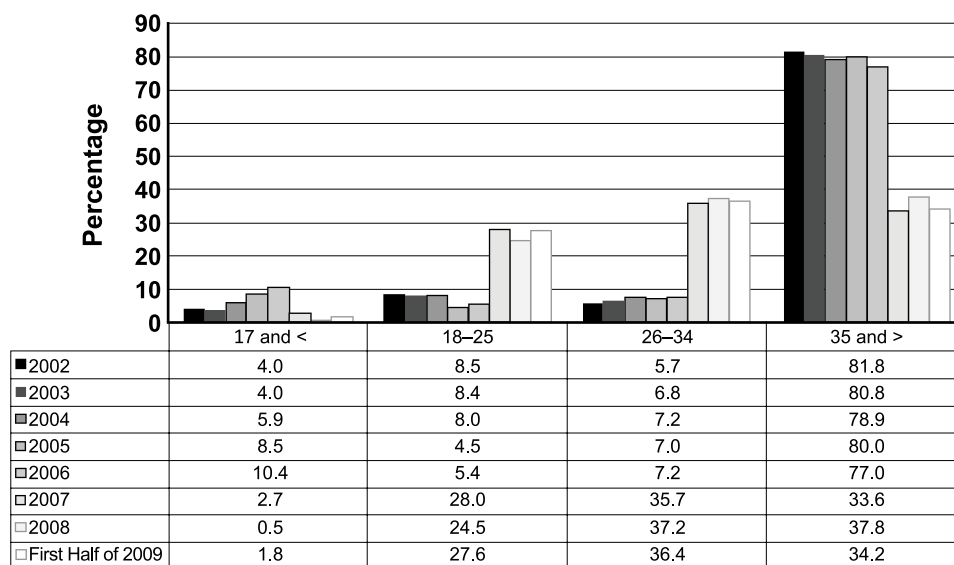
first half of 2008 ($n=173$) to the first half of 2009 ($n=141$), while clandestine methamphetamine laboratory seizures remained stable. Little change was noted from 2006 to 2008 in 30-day methamphetamine use by students in the Missouri School Survey.

- In other areas of the Midwest—Chicago, Cincinnati, and Detroit—methamphetamine indicators continued to be relatively low and stable. Regional differences in numbers of primary methamphetamine treatment admissions were reported by the Chicago area representative, with higher admissions in downstate Illinois than in Chicago in FY 2009.
- Atlanta remained the only area in the South reporting substantial methamphetamine abuse. Indicators there were reported as mixed for the first half of 2009, with higher prevalence in the counties farther from Atlanta, compared with the urban area. Primary treatment admissions for methamphetamine were stable from 2008 to the first half of 2009; prison admissions for possession of methamphetamine decreased

from 456 in CY 2008 to 310 in CY 2009; and numbers and proportions of male arrestees testing positive for methamphetamine decreased slightly from 2007 to 2008. However, the number of drug items seized and identified as methamphetamine by NFLIS increased from 2008 to the first half of 2009, along with calls to the crisis line and self reports of previous methamphetamine treatment among male arrestees. Also in Atlanta, percentages of primary methamphetamine treatment admissions who were in the youngest and oldest age groups, age 17 and under and 35 and older, respectively, were declining as a proportion of total treatment admissions from 2007 through the first half of 2009 reporting period, with higher proportions of those clients 18–34 represented in this group (figure 18).

- Elsewhere in the South, consequences associated with methamphetamine remained low in South Florida, and the Baltimore/Maryland/Washington, DC, area representative stated that methamphetamine was “virtually nonexistent” in those areas.

Figure 18. Percentage of Primary Methamphetamine Treatment Admissions by Age Group, Atlanta: 2002 through 1H 2009



SOURCE: Georgia Department of Human Resources, as reported by Lara DePadilla at the January 2010 CEWG meeting

- CEWG area representatives from the Northeast—Boston, Maine, New York City, and Philadelphia—continued to report very low levels of methamphetamine indicators.
- Several area representatives noted changes in methamphetamine market indicators.
 - While methamphetamine indicators continued to decline in San Diego, market indicators suggested increases in availability. The proportion of San Diego adult arrestees who reported that methamphetamine was more available almost doubled from 2007 to 2008 (from 17 to 31 percent). At the same time, the price of large quantity street purchases of methamphetamine in San Diego dropped in 2008 (from \$10,000–\$20,000 per pound in 2007, to \$8,000–\$15,000 in 2008). This reversed the previous upward price trend that accompanied the gradual decrease in indicators. The San Diego area representative noted that this change in the market may influence future levels and patterns of methamphetamine use.
 - A similar drop in methamphetamine prices occurred in Denver, where mid-2009 wholesale prices had fallen by nearly 25 percent from 2008 levels, and in Los Angeles, where wholesale prices for the first half of 2009 were 25 percent lower than 2008.
 - Prices continued to be high in Phoenix. Methamphetamine purity in the Phoenix area varied according to distance from the Mexican border, with methamphetamine purity highest closer to the border and declines noted with increased distance from the international border, according to the area representative.
- The Texas and St. Louis area representatives continued to report on innovative local production methods. In Texas, anecdotal reports continued to confirm the “one pot” or “shake and bake” methods of producing powdered methamphetamine. Local producers were also reported to make “ice” methamphetamine (using string, a cooler or fish tank, and a battery charger, requiring 30 days in a dark place). Pseudoephedrine control legislation in the St. Louis area has led to more creative ways of networking for the local “cooks” to gain access to the chemicals needed to make methamphetamine. Many small personal network laboratories were reported in the rural areas around St. Louis by the area representative.
- Recent information in 2009 from the DEA that synthetic methamphetamine, made with precursor replacements, was entering the United States from Mexico, was corroborated by the Phoenix area representative. Anecdotal reports from the Phoenix area describe synthetic methamphetamine produced without the use of the precursor chemical ephedrine or pseudoephedrine coming from Mexico.
- The medical director of the San Diego emergency medical services (EMS) was the welcome speaker at the opening session of the January meeting. He described a syndrome, “excited delirium,” that EMS and law enforcement personnel are encountering in increasing numbers when interacting with people who appear to be under the influence of stimulants, such as methamphetamine. Excited delirium is a condition characterized by highly agitated, bizarre behavior and, according to Dr. Dunford, has been identified as a possible cause in several sudden deaths.
- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine abuse in 13 reporting CEWG areas were especially high in Hawaii and San Diego, at approximately 37 and 30 percent, respectively. They were also relatively high in Phoenix and Los Angeles, with respective percentages of approximately 23 and 19 (section IV, table 10; appendix table 1). Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego and Hawaii; second in Phoenix; third in Colorado, Denver, and Los Angeles; fourth in San Francisco; and fifth in Seattle, Texas, and Atlanta (table 2).

- In the first half of 2009, methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu; second in Atlanta, Minneapolis/St. Paul, Phoenix, and San Diego; and third in five CEWG areas—Denver, Los Angeles, San Francisco, Seattle, and Texas (table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 45 percent), followed by Minneapolis/St. Paul (approximately 28 percent), Atlanta (approximately 21 percent), Phoenix (approximately 20 percent), and San Diego and San Francisco (approximately 19 percent each). In contrast, less than 1 percent of drug items identified as containing methamphetamine were reported in nine CEWG metropolitan areas east of the Mississippi, including Chicago, Boston, Detroit, New York City, Miami, Cincinnati, Philadelphia, Maryland, and Baltimore (section IV, figure 21; appendix table 2).
- Estimated numbers of ED visits involving methamphetamine increased in 2 of the 11 reporting CEWG areas in the DAWN system, Boston (123 percent) and San Diego (10 percent), and decreased in 2 areas, San Francisco (22 percent) and Minneapolis/St. Paul (42 percent), from 2004 to 2008. In the period from 2007 to 2008, decreases in methamphetamine-involved ED visits were observed for one CEWG area reporting, Denver (declining by 27 percent) (section IV, figure 30; appendix table 3.5).
- Marijuana continued to be the primary drug of abuse both statewide in Colorado and in the Denver/Boulder area, with all indicators high and most increasing. In the Denver metropolitan area, there was a 224-percent increase in weighted DAWN ED visit rates involving marijuana from 2004 (50.4 per 100,000 population) to 2008 (151.3 per 100,000). Federal drug seizures for marijuana across Colorado, after being relatively stable from 2003, increased dramatically in 2008 (from 444.1 kilograms in 2003 to 24,089 kilograms in 2008). The CEWG area representative reported that as of January 2010, Denver had more medical marijuana dispensaries per capita than any other city in the United States.
- In Hawaii, the number of primary marijuana treatment admissions was reported by the area representative as having increased in the 2009 reporting period over 2008 (2,042 admissions in 2008, and 2,562 admissions projected in 2009 when annualized from first half of 2009 data).
- Marijuana was reported as the primary drug for 23 percent of Los Angeles County treatment admissions, an increase over 2008 levels (19 percent).
- Primary treatment admissions for marijuana continued to increase in the San Diego area, according to the area representative (from 18 percent of total admissions in the first half of 2008 to 21 percent in the first half of 2009). Of drugs seized and identified in San Diego County in the first half of 2009, 54 percent were identified as cannabis/marijuana in the first half of 2008, compared with 52 percent in 2008. Weighted DAWN ED visits showed a statistically significant 25-percent increase from 2006 to 2008, with a nearly significant increase from 2007 (1,622 visits) to 2008 (2,067 visits).

Marijuana/Cannabis

- *All CEWG areas continued to report marijuana indicators at high levels, with some areas reporting increases, and some areas showing either stable or mixed indicators. None of the CEWG areas reported downward trends for marijuana for the first half of 2009.*
- Marijuana indicators increased in several CEWG areas in the West. Indicators were high and rising in Denver, Hawaii/Honolulu, Los Angeles, and San Diego.
- Indicators in other CEWG areas in the western region, although high, remained stable or mixed.

The Texas area representative reported high and stable marijuana indicators (proportions of primary treatment admissions, drugs seized and identified as marijuana/cannabis, and poison control calls), and area representatives from San Francisco, Seattle, and Phoenix reported high and mixed indicators. Weighted DAWN ED data for the San Francisco area showed a 5-percent increase from 2007 to 2008.

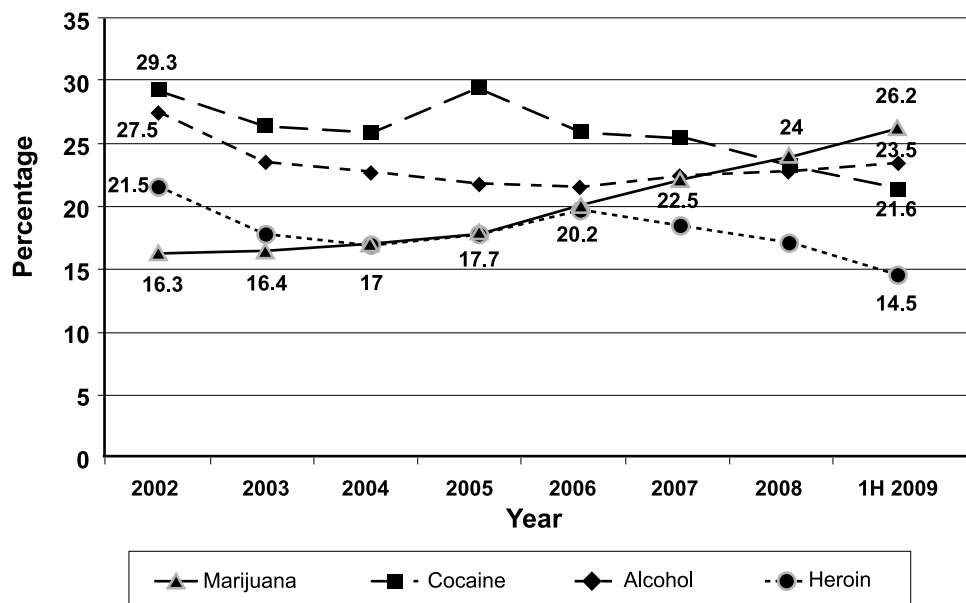
- The area representatives from the midwestern region reported marijuana indicators that were high and stable (Chicago and Cincinnati) or high and mixed (Detroit, Minneapolis/St. Paul, and St. Louis).
- In the southern CEWG region, representatives from Atlanta and South Florida also reported very high and increasing indicators for marijuana. Marijuana remained the most commonly abused substance in Atlanta, where most indicators continued to increase, according to the area representative. Primary treatment admissions for marijuana in metropolitan Atlanta comprised 24 percent of total admissions, compared with 21.8 percent in 2008. Indicators continued to be high and mixed in the Baltimore/Maryland/Washington, DC, area. In Florida, marijuana indicators continued to be high, with marijuana now ranking as the number one primary drug in percentage of total treatment admissions in both Miami/Dade County and Fort Lauderdale/Broward County (in 2008, it ranked number one in Broward County, but was second in Dade County).
- In the Northeast, the increases in marijuana indicators reported in 2008 in New York City continued into the first half of 2009. Marijuana primary treatment admissions increased there to the highest number ever reported ($n=9,928$), representing almost one-quarter of all treatment admissions. Weighted DAWN ED visits increased by 174 percent in 2008 over 2004, and by 25 percent in 2008 compared with 2006. Also in the Northeast, the area representative from Philadelphia reported continuing high levels of marijuana indicators and characterized them as stable or increasing. Marijuana ranked first in primary treatment admissions (at 26.2 percent), first in drug items seized and identified by NFLIS (35.4 percent of all samples), and first in the Philadelphia Adult Probation and Parole Department (APPD) urine drug screens (57.7 percent) in Philadelphia. As a percentage of total substance abuse treatment admissions among the uninsured, marijuana admissions increased from 16.3 percent in 2002 and 24 percent in 2008, to 26.2 percent in the first half of 2009 (figure 19).
- Moderately high but mixed indicators for marijuana were also reported by the Boston and Maine area representatives. The Boston area representative reported that some indicators for marijuana remained stable from CYs 2007 to 2008 (drug arrests for marijuana and drug laboratory samples seized and identified as cannabis/marijuana) and from FYs 2008 to 2009 (the proportion of helpline calls), but weighted DAWN ED visits for marijuana in the Boston area increased by a significant 16 percent from 2007 to 2008 (from 6,556 to 7,624 visits) and by 41 percent from 2006 to 2008. In Maine, marijuana indicators were mixed, with the proportion of arrests for marijuana rising from 16 percent in 2008 to 23 percent in 2009. However, drug items seized and identified as cannabis/marijuana and treatment admissions remained stable.
- The availability of marijuana was reported as very high by CEWG area representatives in Cincinnati, Denver, Detroit, and New York City, and there were reports of diminishing stigma regarding marijuana use, according to the Denver area representative. Both the Texas and New York City area representatives reported use of blunt cigars as a mode of administration for marijuana in their areas. In New York City, marijuana in a blunt cigar often serves as the base to which other drugs are added, according to the area representative.
- Some demographic shifts in marijuana indicators were reported. In Los Angeles, female treatment admissions increased (36.2 percent of admissions in the first half of 2009, compared with 31.2 percent of admissions in 2008, and 24.8 percent in

2004). The Detroit area representative reported a decline in male treatment admissions, from 71.8 percent in FY 2008 to 64.3 percent in FY 2009. In San Francisco, the area representative noted a significant increase of 22 percent in female weighted DAWN ED visits from 2007 to 2008. However, in San Diego, the area representative reported that female adult arrestees testing positive for marijuana reached a recorded 9-year low in the first half of 2009, at 26 percent (the 9-year range was from 27 to 33 percent).

- Several CEWG area representatives discussed marijuana indicator data on adolescents and young adults. In Los Angeles, the majority of marijuana treatment admissions were adolescents younger than 18, and marijuana was the primary drug for treatment admissions for youth in Philadelphia and Seattle. The San Francisco area representative reported an increase in weighted DAWN ED visits involving marijuana for patients age 18 to 20 (a 29-percent increase from 2007 to 2008) and age 21 to 24 (a 21-percent increase from

2007 to 2008). According to the area representative from South Florida, the 2009 Florida Youth Substance Abuse Survey reported an increase in past-30-day use of marijuana for 12th graders statewide (21.8 percent, compared with 18.3 percent in 2006 and 10.4 percent in 2008). The Minneapolis/St. Paul area representative reported that the average age of first marijuana use in the first half of 2009 was 14.3 years, the youngest age within any drug category in that area. However, trends varied in other CEWG areas. Primary marijuana treatment admissions for clients under 18 declined in Detroit from FY 2008 to FY 2009, from 38.7 to 29.9 percent. In Texas, the area representative noted an increasing older cohort of marijuana abusers, reporting a 94-percent increase in weighted DAWN ED visits for marijuana in Houston among the 55 to 64 age group from 2007 to 2008. Figure 20 shows the increases in mean age at first treatment admission among primary marijuana admissions in Colorado and Denver from the first half of 2001

Figure 19. Percentage of Primary Treatment Admissions Among Uninsured Publicly Funded Admissions for Marijuana, Compared With Heroin, Cocaine, and Alcohol, Philadelphia: 2002–1H 2009

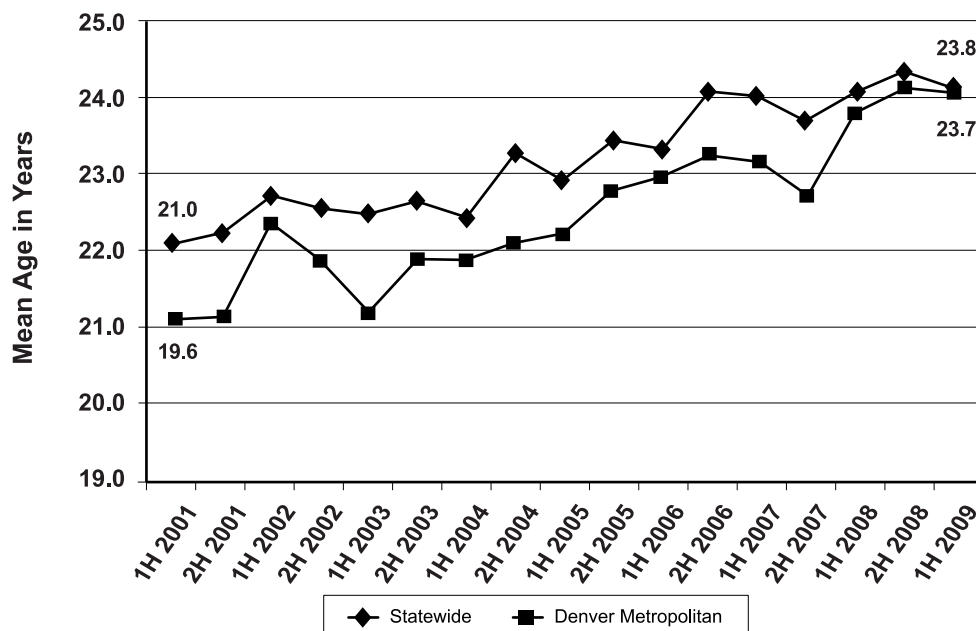


SOURCE: Behavioral Health Initiative Client Data System (Uninsured Clients), as reported by Samuel Cutler at the January 2010 CEWG meeting

to the first half of 2009, with recent increases from the second half of 2007.

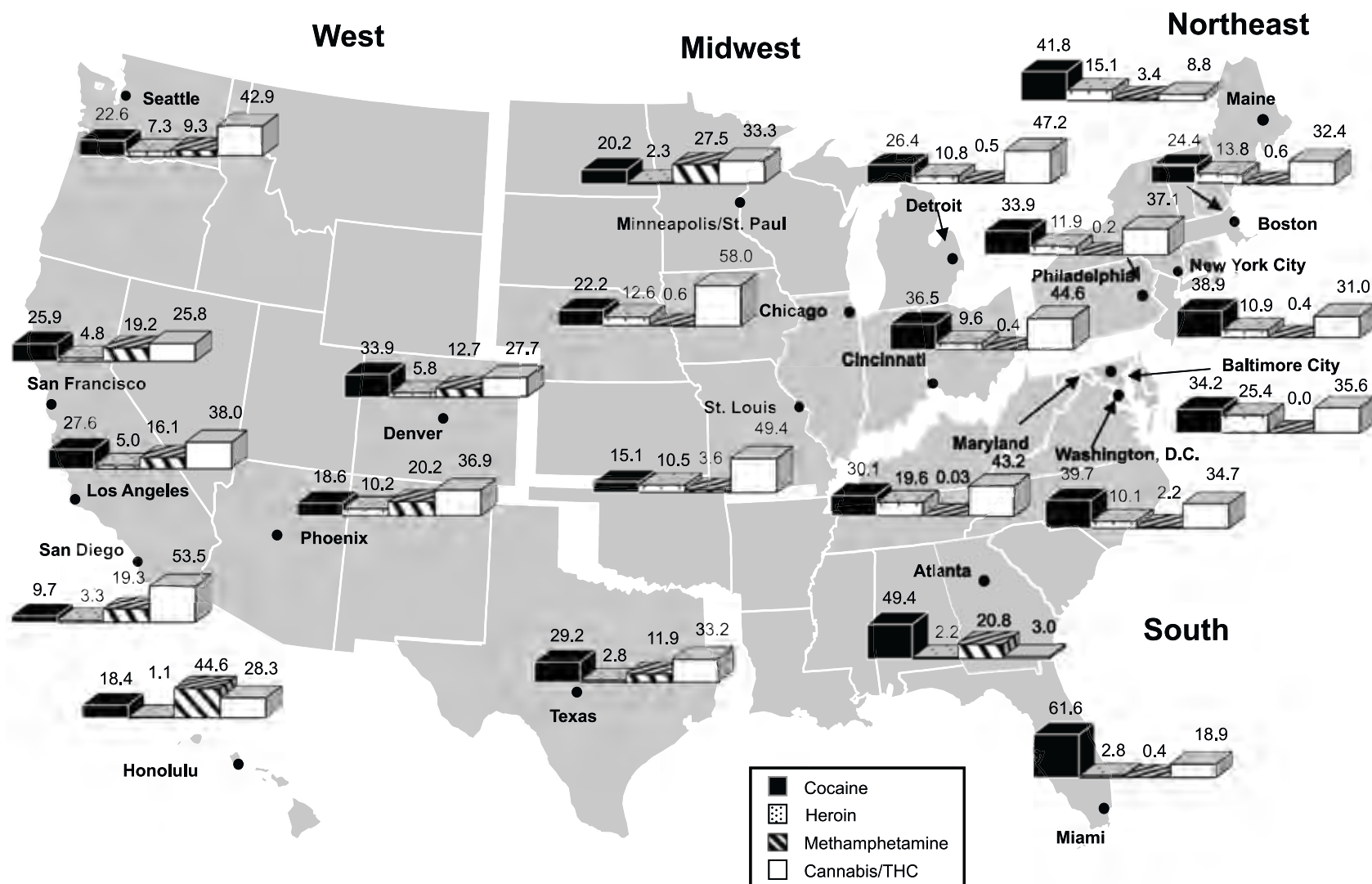
- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in the first half of 2009 in Ft. Lauderdale/Broward County (36.0 percent), followed by Miami/Dade County (32.4 percent) and Cincinnati (30.3 percent). The lowest proportions of such admissions were in Boston (4.7 percent) (section IV, table 11; appendix table 1).
- Marijuana ranked first as the primary drug problem in total drug admissions, including alcohol admissions, in 4 of 23 CEWG reporting areas; these were Ft. Lauderdale/Broward County, Miami/Dade County, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in nine additional areas: Atlanta, Cincinnati, Minneapolis/St. Paul, St. Louis, Denver, San Diego, and Seattle, and the States of Colorado and Texas (table 2).
- Cannabis/marijuana ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in the first half of 2009 in all CEWG areas, with the exception of Atlanta and Maine. Cannabis ranked in first place among identified drugs in 14 of 22 CEWG areas in this reporting period: Baltimore, Maryland, Boston, Philadelphia, Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, St. Louis, Los Angeles, Phoenix, San Diego, Seattle, and Texas. It ranked second in the remaining six areas (table 1). The highest proportions of marijuana items identified in the NFLIS system were in Chicago, San Diego, and St. Louis, at approximately 58, 54, and 49 percent, respectively (section IV, figure 21; appendix table 2).
- Estimated DAWN ED visits involving marijuana increased in 5 of 11 reporting areas from 2004 to 2008. Respective increases in estimated marijuana-involved ED visits of 45, 224, 114, 174, and 147 percent were reported in Boston, Denver, Detroit, New York City, and San Diego.

Figure 20. Mean Age of First Admission to Treatment Among Primary Marijuana Treatment Admissions, Colorado and Denver: 2001–2009 in Half-Yearly Intervals



SOURCE: Drug/Alcohol Coordinated Data System (DACODS), Division of Behavioral Health (DBH), Colorado Department of Human Services (CDHS), as reported by Kristen Dixon at the January 2010 CEWG meeting

Figure 21. Percentages of Cocaine, Heroin, Methamphetamine, and Marijuana Items Analyzed by Forensic Laboratories in 22 CEWG Areas in Four U.S. Regions, Each as a Percentage of Total Items Analyzed: 1H 2009¹



¹Data are for January–June 2009 (see appendix tables 2.1–2.22. Data are subject to change; data queried on different dates may reflect differences in the timing of data analysis and reporting.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010

Increases were also observed in four areas from 2007 to 2008; these were Boston, Chicago, Houston, and San Francisco. They ranged from 5 percent in San Francisco to 59 percent in Houston (section IV, figure 32; appendix table 3.6).

MDMA/Ecstasy and Other Club Drugs, Including MDA, GHB/GBL, LSD, and Ketamine

- **MDMA/Ecstasy:** *MDMA (3,4-methylenedioxymethamphetamine, or ecstasy) indicators continued to be low when compared with other drug indicators. However, MDMA abuse remained a problem in several CEWG areas, as reported by CEWG representatives.*
- In the western region, while MDMA indicators were reported as low by the Denver area representative, there was a 30-percent increase in weighted DAWN ED visits involving MDMA in Denver from 2007 to 2008. Additionally, primary MDMA treatment admissions increased in the first half of 2009, compared with the first half of 2008. In San Francisco, where most indicators for MDMA were stable, weighted DAWN ED visits involving MDMA increased significantly by 56 percent in 2008, compared with 2007 (from 188 visits in 2007 to 293 visits in 2008). The area representative from Phoenix reported a growing concern regarding MDMA as a potential emerging problem in that area, one that warrants continued monitoring. Items seized and identified by NFLIS as MDMA in Phoenix in the first half of 2009 increased slightly over the first half of 2008, and weighted DAWN ED visits involving MDMA in 2008 totaled 220—the largest number in 4 years. The Phoenix Police Department dismantled an MDMA drug ring in 2009, arresting 10 dealers; at the same time, 2 individuals were arrested for possession of chemicals to manufacture MDMA. The San Diego and Los Angeles area representatives reported MDMA indicators as mostly stable, or slightly increasing, in the first half of 2009 (drug items seized and identified as MDMA/ecstasy and treatment admissions for ecstasy). However, self-reported use among juvenile arrestees in San Diego decreased from 2007 (20 percent) to 2008 (8 percent).
- In the Midwest, the Chicago area representative reported that MDMA ED visit rates increased significantly in 2008, compared with 2004 and 2007, and that MDMA continued as a popular drug in low-income urban neighborhoods. Availability and use indicators continued to increase in Cincinnati, according to the area representative, although they remained at low levels. In Detroit, ecstasy use was still evident in weighted DAWN ED reports (where visits increased significantly from 2004 to 2008) and Medical Examiner (ME) reports, but the number of calls to the poison control center continued to decline from the peak in 2004. Anecdotal reports of MDMA popularity in clubs and colleges were reported by the St. Louis area representative.
- In the southern region of the country, MDMA indicators continued at low levels, with stable or decreasing indicators. Methamphetamine and BZP (1-benzylpiperazine) continued to be detected in ecstasy tablets in the South Florida area, according to the area representative.
- MDMA indicators remained very low across all CEWG areas in the Northeast, but drug items identified as containing MDMA in NFLIS forensic laboratories in New York City moved from 11th place in frequency of total drugs identified in the first half of 2008 to 6th place in the first half of 2009. The area representative from Maine reported that MDMA was found in 12 percent of items seized and identified as methamphetamine in that State.
- MDMA was the fourth most frequently identified drug item in Chicago, Minneapolis/St. Paul, and Honolulu in the first half of 2009 (table 1; section IV, table 12). It ranked fifth in proportion of drug items identified in forensic laboratories in six areas—Maine, Detroit, Denver, Los Angeles, San Diego, and San Francisco. MDMA represented 4.2, 3.8, 3.7, 2.9, 2.8, and 2.6 percent of total drug items identified in forensic laboratories in the first half of 2009 in San Francisco, Maine,

Minneapolis/St. Paul, Denver, Los Angeles, and Atlanta, respectively (section IV, table 12).

- **Other Club Drugs (Including MDA, GHB/GBL, LSD, Ketamine):** *GHB (Gamma hydroxybutyrate), ketamine, and MDA (3,4-methylenedioxymphetamine) appeared relatively infrequently in indicator data for all areas. However, LSD (lysergic acid diethylamide), ketamine, and MDMA remained drugs of concern to CEWG representatives.*
- In New York City, the area representative reported a significant 72-percent increase in weighted DAWN ED visits for LSD from 2004 to 2008; visits also increased significantly, by 91 percent, from 2006 to 2008.
- GHB drug items were not among the top 10 drug items identified for any CEWG area in the first half of 2009, although 6 of 22 areas reported 1 or more such items, including Atlanta, Chicago, New York City, San Diego, San Francisco, and Texas (section IV, table 13). Ketamine was among the drug items identified in the NFLIS system in the first half of 2009 in 16 of 22 areas, with exceptions being Cincinnati, Honolulu, Minneapolis/St. Paul, St. Louis, Seattle, and Washington, DC. Ketamine did not figure among the top 10 ranked drug items in any CEWG area (section IV, table 13).
- In the first half of 2009, LSD was among identified drug items in 12 of 22 CEWG areas: Atlanta, Boston, Chicago, Denver, Los Angeles, Maine, Miami, New York City, Phoenix, San Francisco, Seattle, and Texas, although it made up 1 percent or less of all drug items identified in those areas (section IV, table 13).
- MDA was reported among items identified in 8 of 22 areas: Atlanta, Baltimore, Denver, Honolulu, New York City, Philadelphia, Phoenix, and San Francisco (section IV, table 13). Like ketamine, GHB, and LSD, MDA did not figure among the top 10 most frequently identified drug items in any CEWG area in the first half of 2009 (table 1).

Phencyclidine (PCP)

- *Phencyclidine (PCP) persisted on the drug scene in CEWG areas, mostly in the South and the Northeast.*
- In the Baltimore/Maryland/Washington, DC, area, PCP continued as a drug of concern; PCP was the third most frequently found drug by HIDTA in Washington, DC. However, the percentage of adult arrestees testing positive for PCP decreased. PCP abuse continued also in Philadelphia, where PCP is primarily smoked in combination with marijuana in blunts. In New York City, weighted DAWN ED visits for PCP increased significantly by 42 percent from 2006 to 2008.
- In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in the first half of 2009. PCP was also among the top drug items identified in Philadelphia and Los Angeles, where it ranked sixth and seventh, respectively. PCP ranked eighth in New York City and ninth in Chicago and Seattle in the reporting period (table 1).
- Washington, DC, and Philadelphia reported the highest percentages of PCP drug items identified in the first half of 2009 in NFLIS data, at 5.6 and 2.8 percent of drug items identified, respectively (section IV, table 13).

Other Drugs and Drug Abuse Patterns/Issues

BZP:

- BZP, a synthetic stimulant that is illegal and has no accepted medical use in the United States, continued during this reporting period as an emerging drug of concern in several CEWG areas across all regions. BZP was permanently controlled in 2004 as a Schedule I substance under the Controlled Substance Act.
 - In the western region, area representatives from Denver, Seattle, and Texas reported continuing increases in BZP abuse. While BZP was not identified as a major drug of abuse in

Denver, the area representative reported that it may become a drug of interest in the future, especially in combination with MDMA and TFMPP (1-3-(trifluoromethylphenyl)-piperazine). According to the area representative, the DEA reported confiscating a vehicle transporting 4,000 pills (alleged to be MDMA) from California to Colorado. However, after being analyzed, it was determined the pills were actually BZP and TFMPP. In Seattle, the proportion of drug items identified as BZP in forensic laboratories in the NFLIS system increased from none in 2007 to 3 percent ($n=38$) in the first half of 2009. Drug items seized and identified as BZP also continued to increase in Texas, with 367 seized and identified in 2009, up from 19 in 2007 and 312 in 2008.

- In the Midwest, BZP ranked in the top 10 list of most frequently seized and identified drug by NFLIS in the first half of 2009 in Chicago, Detroit (where it climbed from 10th in 2008 to 7th in rank), and St. Louis (where it moved from 10th place in 2008 to 5th in the first half of 2009).
- BZP also ranked in the NFLIS top 10 drugs seized and identified in Baltimore and Florida's Miami/Ft. Lauderdale/Pompano Beach MSA in the southern region.
- In New York City, the number of drug items seized and identified by NFLIS increased from just 4 items in the first half of 2008 to 101 items in the first half of 2009, moving it from 32nd on the list of total drugs identified to 14th in rank.
- In the first half of 2009, BZP emerged among the identified drugs in NFLIS forensic laboratories in all 22 CEWG areas, compared with 18 of 22 areas in CY 2008 (section IV, table 13). BZP

ranked among the top 10 most frequently identified drug items in NFLIS data in the first half of 2009 in 12 of 22 CEWG areas. BZP ranked 5th in Chicago and St. Louis; 6th in Honolulu and Seattle; 7th in Detroit and Denver; 8th in Miami, Washington, DC, and Texas; 9th in Los Angeles, and 10th in Baltimore and Maine.

TFMPP:

- TFMPP⁷ is a synthetic substance with no accepted medical use in the United States that is abused for its hallucinogenic effects. TFMPP is currently an uncontrolled substance and remains a concern in a few CEWG areas.
- In the first half of 2009, drugs seized and identified by NFLIS as TFMPP in Texas increased substantially over 2007 and 2008. There were only 2 such reports in 2007; these grew to 66 in 2008 and 71 in 2009.
- According to NFLIS data for the first half of 2009, TFMPP ranked ninth among drug items identified in forensic laboratories in Atlanta, where 81 such drug items were identified, and seventh in Washington, DC, with 16 identified TFMPP drug items (table 1). TFMPP drug items constituted 1.4 percent of Atlanta's drug items in the first half of 2009, and they represented nearly 1 percent of those for Washington, DC (section IV, table 13).

Foxy Methoxy (5-Methoxy-N, N-diisopropyltryptamine, or 5-MeO-DIPT):

- Foxy Methoxy⁸ is a synthetic substance abused for its hallucinogenic effects that is illegal in the United States and is controlled as a Schedule I substance under the Controlled Substance Act. Drug items containing Foxy Methoxy were identified in the NFLIS system data for the first half of 2009 in one CEWG area only: San Francisco ($n=2$) (section IV, table 13, footnote 1).

⁷More information on TFMPP can be found in the Federal Register Notice 68 FR 52872. It should be noted that TFMPP is frequently combined with BZP to mimic MDMA, and since it is not a controlled drug, many states, including Washington, do not report TFMPP in the NFLIS data system, according to the CEWG area representative from Seattle.

⁸More information on 5-MeO-DIPT can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/5meodiapt.htm.

Salvia Divinorum:

- *Salvia divinorum*⁹ is a perennial herb native to Mexico, whose active ingredient, salvinorin A, produces hallucinogenic effects when it is smoked or chewed. It is not currently federally controlled, although some States control it as a Schedule I drug. Seizures of *salvia divinorum* have seen a steady increase since 2004.

Psilocin:

- Psilocin (also called psilocin/psilocybin and psilocybine) is an hallucinogen that ranked 8th in Minneapolis/St. Paul, 9th in Denver, and 10th in Phoenix in the NFLIS data for the current reporting period (table 1). Psilocin/psilocybin was reported among drug items in forensic laboratories in 19 of 22 CEWG areas in the first half of 2009 (section IV, table 13).

Carisoprodol (Soma®):

- Carisoprodol¹⁰ is a muscle relaxant and central nervous system depressant that is available by prescription as Soma®. It is not controlled on the Federal level, but several States have scheduled Soma® as a controlled substance.
- NFLIS data for the first half of 2009 showed that carisoprodol was identified among drug items analyzed in area forensic laboratories in 14 of 22 CEWG reporting areas: Atlanta, Boston, Chicago, Denver, Detroit, Honolulu, Los Angeles, Miami, Minneapolis/St. Paul, Phoenix, St. Louis, San Diego, San Francisco, and Texas (section IV, table 13). In the first half of 2009, drug items containing carisoprodol ranked 9th in Texas and Phoenix among the top 10 most frequently identified NFLIS drug items in the period (table 1).

Antipsychotics:

- **Quetiapine**, an antipsychotic drug, appeared for the first time in NFLIS data for Boston (70

items) and Texas (164 items) in 2008, and again in the first half of 2009.

- In Philadelphia, where deaths in which quetiapine was detected increased in 2008 over 2007 (from 29 to 49 deaths), the area representative reported stable indicators for the first half of 2009. The area representative projects decreases in cases and detections for full-year 2009, based on the data from the first half of the year.
- In Maine, the CEWG representative reported that 8 percent of drug-induced deaths in 2008 were due to antipsychotics as a general category.

Levamisole:

- During this reporting period, several CEWG area representatives reported data pertaining to levamisole, a veterinary antiparasitic medication not approved for human use in the United States. Data pertaining to levamisole and cocaine are reported under the Cocaine heading in this section of the report. Data available subsequent to the June 2009 CEWG meeting from the DEA Cocaine Signature Program indicate that in early 2009, levamisole was detected in 69 percent of cocaine bricks tested from bulk seizures. The CEWG representative from Maine also reported that levamisole has been detected in heroin in Maine. Levamisole has been linked to agranulocytosis, in which there is a marked decrease in white blood cells suppressing immune function and the body's ability to fight infection. On September 21, 2009, SAMHSA released a Public Health Alert regarding the risk posed by cocaine laced with levamisole. The Public Health Alert can be viewed on the SAMHSA website at: <http://www.samhsa.gov/newsroom/advisories/090921vet5101.aspx>.

Other Emerging Drugs:

- The report from the representative from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) highlighted new drugs

⁹More information on *Salvia divinorum* is available at: http://www.usdoj.gov/dea/drugs_concern/salvia_d/salvia_d.htm and at <http://www.drugabuse.gov/infofacts/salvia.html>.

¹⁰Information on carisoprodol and Soma® can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/carisoprodol.htm.

entering the global market. Sophisticated marketing methods and the Internet now facilitate international distribution and increased availability of new drugs. New drug trends in one part of the world serve as an alert to potential new issues in other regions. Synthetic drugs are a concern in the emerging drug market. In 2008 and 2009, the EMCDDA Early Warning System identified **synthetic cannabinoids** that had been added to herbal mixtures available predominantly through Internet-based suppliers. Smokable herbal mixtures have been marketed under the name, “**Spice**.” An EMCDDA report, “Understanding the ‘Spice’ Phenomenon,” was released by the EMCDDA in November 2009 (<http://www.emcdda.europa.eu/publications/thematic-papers/spice>). “Spice” and THC-like synthetic cannabinoids were also identified as substances of interest by the U.S. DEA at the June 2009 CEWG meeting. The EMCDDA representative reported that during 2009, increasing reports of **synthetic cathinones** (a naturally occurring stimulant found in the khat plant) have been received and are being investigated, and that **mephedrone** (a stimulant drug with effects similar to MDMA) had emerged as a new drug in Europe.

International Drug Abuse Patterns and Issues

Europe:

- Drug abuse trends in Europe were updated for the CEWG by at the January meeting by a representative from the EMCDDA, the agency that collects drug information from 27 European Union (EU) member states, and Croatia, Turkey, and Norway. According to the most recent assessment of the European drug situation, released in November 2009, cannabis was the most prevalent drug of abuse in the member countries; 22 percent of European adults (74 million) reported lifetime cannabis use, an increase over the previous year, when 22 million reported lifetime use. Cocaine was the second most commonly consumed drug in the EU, with trends moving upwards. Four million adults reported

cocaine use. Heroin use was reported as stable, after previous declines. Use of ecstasy remained stable overall, but recent studies showed that the content was changing. Up to 2007, most tablets sold as ecstasy contained MDMA or a close analogue; in 2009, as much as one-half of the ecstasy tablets sold in some European markets appeared to contain piperazines (e.g., mCPP, or 1-(m-chlorophenyl)piperazine).

- The EMCDDA representative reported that the EU Early Warning System has reported more than 100 substances. In 2008 and 2009, the EMCDDA system identified synthetic cannabinoids that had been added to herbal mixtures available predominantly through the Internet. At the time of this report, 10 new synthetic cannabinoids, seen as the latest stage in the development of “designer drugs,” had been identified. Reports of synthetic cathinones were also being investigated by the EMCDDA.

Caribbean:

- According to the representative in attendance at the meeting from the Inter-American Drug Abuse Control Commissions (CICAD), the antidrug agency in the Caribbean affiliated with the Organization of American States, marijuana is the most widely used illicit drug in the Caribbean. In most cases, marijuana use is even more prevalent than tobacco. Other substances used include cocaine, crack cocaine, and ecstasy, although the rates of past-year use of these substances for most countries was less than 1 percent in 2008.
- While treatment data in this region are very limited, data from four countries show unique patterns of use. The primary drugs for people seeking treatment in 2008 varied widely from country to country: marijuana was the primary drug in Antigua, accounting for 70 percent of treatment admissions there; Grenada reported polydrug use (without cocaine) as the main problem, representing 40 percent of total admissions; crack cocaine accounted for 81 percent of admissions in Suriname; and alcohol accounted for approximately one-half of all treatment admissions in Haiti.

- Generally, the Caribbean region has not been a major source of drugs, according to the CICAD. Several countries, however, with good air linkages to North America and Europe, however, have been used as transshipment points for traffickers moving their products from South America.

Canada:

- Marijuana/cannabis continued to be the dominant illicit drug in Canada, according to the representative from Health Canada. Cannabis led in both self-reported past-year use and laboratory analysis of exhibits from seized (by police and border services) substances. Although the number of cannabis exhibits examined had declined, compared with 2004, there was a slightly increasing

trend in the number of exhibits analyzed from 2005 to 2008.

- Cocaine followed as the second most frequently analyzed drug in Canada in 2008. However, the number of exhibits analyzed and identified as cocaine decreased slightly in 2008. Methamphetamine, MDMA/ecstasy, and prescription opioids rounded out the top five most frequently analyzed drugs in Canada from 2004 to 2008. In 2008, 28 percent of Canadians age 15 and older indicated that they had used (including for medical use) a pharmaceutical drug (opioid pain reliever, stimulant, sedative, or tranquilizer) in the past year.

Table 1. NFLIS Top 10 Drug Items Analyzed by CEWG Area and Rank (Based on Frequency): January–June 2009

CEWG Areas	Cocaine/ Crack	Heroin	Oxy- codone	Hydro- codone	Alprazolam	Clonaz- epam	Metham- phetamine	Cannabis/ THC	MDMA	Phencyc- lidine (PCP)	Other Drugs
SOUTHERN REGION											
Atlanta	1	8	5	4	3	--	2	6	7	--	1-(3-Trifluoromethylphenyl)- piperazine=9; Amphetamine=10
Baltimore	2	3	5	--	6	7	--	1	8	--	Buprenorphine=4; Methadone=9; 1-Benzylpiperazine=10
Maryland	2	3	4	9	6	7	--	1	8	--	Buprenorphine=5; Methadone=9
Miami	1	3	7	10	4	--	9	2	6	--	Hallucinogen (Nonspecified)=5; 1-Benzylpiperazine=8
Washington, DC	1	3	6	--	--	--	5	2	--	4	1-(3-Trifluoromethylphenyl)-piperazine=7; 1-Benzylpiperazine=8; Bupren- orphine=8; 6-Monoacetylmorphine=10
NORTHEASTERN REGION											
Boston	2	3	4	8	7	6	--	1	9	--	Buprenorphine=5; Methadone=10
Maine	1	2	4	7	--	--	6	3	5	--	Buprenorphine=7; Methadone=9; 1-Benzylpiperazine=10; Morphine=10
New York City	1	3	5	9	4	10	--	2	6	8	Methadone=7
Philadelphia	2	3	4	9	5	8	--	1	--	6	Codeine=7; Diazepam=10
MIDWESTERN REGION											
Chicago	2	3	--	6	8	--	7	1	4	9	1-Benzylpiperazine=5; Acetamino- phen=10
Cincinnati	2	3	4	5	7	10	10	1	6	--	Diazepam=8; Methadone=9
Detroit	2	3	8	4	6	--	9	1	5	--	1-Benzylpiperazine=7; Codeine=10; Diazepam=10
Minneapolis/ St. Paul	3	5	6	9	--	--	2	1	4	--	Amphetamine=7; Psilocybin/Psilocyn=8; Acetamino- phen=10
St. Louis	2	3	8	6	7	--	4	1	10	--	1-Benzylpiperazine=5; Pseudoephed- rine=9
WESTERN REGION											
Denver	1	4	6	8	10	--	3	2	5	--	1-Benzylpiperazine=7; Psilocin=9
Honolulu	3	5	--	--	8	--	1	2	4	--	1-Benzylpiperazine=6; Acetaminophen=6 Methadone=9; Mor- phine=9
Los Angeles	2	4	10	6	8	--	3	1	5	7	1-Benzylpiperazine=9
Phoenix	3	4	5	7	8	10	2	1	6	--	Carisoprodol=9; Psilocin=10
San Diego	3	4	7	6	8	9	2	1	5	--	Diazepam=10; Morphine=10
San Francisco	1	4	6	7	--	10	3	2	5	--	Methadone=8; Morphine=9
Seattle	2	4	5	7	--	--	3	1	10	9	1-Benzylpiperazine=6; Buprenorphine=7; Cathinone=10
Texas	2	6	--	5	4	10	3	1	7	--	1-Benzylpiperazine=8; Carisoprodol=9

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; data are subject to change and may differ according to the date on which they were queried; see appendix 2

Table 2. Top-Ranked Primary Drugs as a Percentage of Total Treatment Admissions, Including Primary Alcohol Admissions, in 23 CEWG Areas¹, by Region and Ranking: 1H 2009 (The First Half of 2009)²

CEWG Areas ³	Alcohol	Cocaine/ Crack	Heroin ⁴	Other Opiates/ Opioids	Metham- phetamine ⁵	Marijuana/ Cannabis	Other Drugs/ Unknown
SOUTHERN REGION							
Atlanta	1	3	6	4	5	2	7
Baltimore	2	3	1	5	7	4	6
Ft. Lauderdale/Brow- ard County	2	4	6	5	7	1	3
Maryland	1	4	2	5	7	3	6
Miami/Dade County	3	2	5	6	7	1	4
NORTHEASTERN REGION							
Boston	2	3	1	5	7	4	6
Maine	1	5	4	2	7	3	6
New York City	1	4	2	6	7	3	5
Philadelphia	2	3	4	6	7	1	5
MIDWESTERN REGION							
Chicago	2	3	1	6	7	4	5
Cincinnati ^{4,5}	1	4	3	-- ⁴	6 ⁵	2	5
Detroit	2	3	1	5	7	4	6
Minneapolis/St. Paul	1	5	4	3	6	2	7
St. Louis	1	4	3	5	6	2	7
WESTERN REGION							
Colorado	1	4	5	6	3	2	7
Denver	1	4	5	6	3	2	7
Hawaii	2	5	6	NR ⁶	1	3	4
Los Angeles	2	5	4	6	3	1	7
Phoenix ⁷	1	5	4	6	2	3	7
San Diego	3	5	4	6	1	2	7
San Francisco ⁴	2	3	1	-- ⁴	4	5	6
Seattle	1	3	4	6	5	2	7
Texas ⁵	1	3	4	6	5 ⁵	2	7

¹The CEWG area not included in the table due to lack of availability of treatment admissions data for the reporting period is Washington, DC, in the southern region.

²Data are for January–June 2009.

³Data for Atlanta include data for the 28-county Atlanta Metropolitan Statistical Area. Boston data include data for the cities of Boston, Brookline, Revere, Chelsea, and Winthrop. Data for New York City are for the Five Boroughs of New York. Cincinnati data are for Hamilton County, while Minneapolis/St. Paul data pertain to metropolitan counties: Anoka, Dakota, Hennepin, Ramsey, and Washington. Data for St. Louis include data for the City of St. Louis and the County of St. Louis, as well as Jefferson, Franklin, Lincoln, St. Charles, and Warren Counties. Denver data are for the Denver/Boulder area. Data for Los Angeles cover Los Angeles County, while data for Phoenix are for Maricopa County, for San Diego, San Diego County, for San Francisco, San Francisco County, and for Seattle, King County.

⁴Heroin and other opiates are grouped together for Cincinnati and San Francisco and are reported for heroin only.

⁵Methamphetamine, amphetamine, and MDMA are grouped together for Cincinnati; methamphetamine and amphetamine are grouped together for Texas.

⁶NR=Not reported by the CEWG area representative.

⁷Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: January 2010 State and local CEWG reports

Section III. CEWG Update Briefs and International Reports—January 2010 CEWG Meeting

Introduction

The 67th semiannual meeting of the Community Epidemiology Work Group (CEWG) was held on January 20–22, 2010, in San Diego, California. During this meeting 20 CEWG area members reported on current drug trends and patterns in their areas, based on data newly available since the June 2009 CEWG area report. Four international presentations were also given. The following Update Briefs and International Reports were provided by the speakers.

CEWG AREA UPDATE BRIEFS

Drug Abuse Patterns and Trends in Atlanta—Update: January 2010

Lara DePadilla, Ph.D.

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Overview of Findings: Cocaine and marijuana remained the dominant drugs of abuse in the metropolitan Atlanta area.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine was the most mentioned drug among prison admissions and in National Forensic Laboratory System (NFLIS) drug seizure data in the 28 metropolitan area counties. Treatment admissions data indicated that cocaine was the primary substance in 20 percent of admissions. Frequency of cocaine reported as a secondary drug of choice among users admitted for heroin use increased, up to 31.5 percent in the

first half of 2009, compared with 27.2 percent in 2008. Atlanta's cocaine users continued to be predominantly African-American, male, and older than 35. Three-quarters of all cocaine users who entered treatment preferred to smoke the drug, continuing a stable proportion that has been in place for more than one-half of a decade. In all five major counties closest to the center of the city (Fulton, DeKalb, Cobb, Gwinnett, and Clayton) prison admissions decreased in 2009, compared with 2008. Overall prison admissions for possession of cocaine in the 28 metropolitan area counties decreased, from 961 in 2008 to 727 in 2009. In contrast, prison admissions for possession with intent to distribute increased, from 120 in 2008 to 250 in 2009. Cocaine use is largely found in the five counties closest to the city, with 79.3 percent of the treatment admissions in the 28-county area. Among male arrestees in 2008 in Fulton County, the percentage testing positive for cocaine decreased, from 45.8 percent in 2007 to 39.8 percent in 2008. In the same population, self reports of ever receiving treatment for crack cocaine increased, from 39.3 percent in 2007 to 47.4 percent in 2008; self reports of ever receiving treatment for powder cocaine remained stable over the same period. **Marijuana** remained the most commonly used substance in Atlanta. Crisis line calls from the third quarter of 2009 indicated that calls for marijuana will represent a half-yearly peak, compared with half-yearly numbers since the second half of 2006. NFLIS data indicated an increase to 177 seizures in the first half of 2009, compared with 101 in the same period in 2008. The percentage of treatment admissions in the first half of 2009 was 24 percent, up from 21.8 percent in 2008. Among treatment admissions for which methamphetamine was the primary drug, marijuana as secondary drug of choice increased, from 23.3 percent in 2008 to 26

percent in the first half of 2009. Prison admissions for possession of marijuana decreased, from 84 in 2008 to 59 in 2009. However, prison admissions for possession with intention to distribute marijuana increased to 304 in 2009, from 140 in 2008. Marijuana appeared to be more spread across urban and nonurban counties than cocaine, with 68.5 percent of treatment admissions in the five counties closest to the city and 31.5 percent in the remaining counties. Among male arrestees in 2008 in Fulton County, the percentage testing positive for marijuana increased slightly, from 35.0 percent in 2007 to 39.2 percent in 2008. The percentage of male arrestees self-reporting any treatment for marijuana remained stable across both years. There was variability with regard to the use of **methamphetamine** across indicators. Treatment admissions for methamphetamine were stable between 2008 and the first half of 2009. During the first half of 2009, females entering substance abuse treatment for methamphetamine outnumbered males, although the discrepancy was not as great as in the same period of 2008. The proportion of methamphetamine-related primary treatment admissions smoking the drug remained at 60 percent—consistent with the previous year, and continuing the leveling off that began after six consecutive increases in smoking-related primary methamphetamine-related admissions. Whites remained the most frequent users of methamphetamine, representing 97 percent of all treatment admissions. Nearly equal percentages of methamphetamine users were between the ages of 26 and 34 and 35 or older (36.4 versus 34.2 percent). NFLIS showed an increase in drugs seized identified as methamphetamine. Prison admissions for possession of methamphetamine decreased, from 456 in 2008 to 310 in 2009, while prison admissions for possession with intent to distribute increased, from 65 in 2008 to 149 in 2009. Unlike cocaine and marijuana, methamphetamine use was found primarily in counties farther from Atlanta, with only 30 percent of treatment admissions in the counties closest to the city. Among male arrestees in 2008 in Fulton County, the percentage testing positive for methamphetamine decreased slightly from 2007

to 2008, while self reports of ever receiving treatment for methamphetamine increased, from 48.3 percent in 2007 to 59.2 percent in 2008. **Heroin** indicators continued to show stable levels of use. The percentage of treatment admissions in the first half of 2009 was 4.9 percent, compared with 4.6 percent in 2008. Admissions were concentrated in the urban counties, similar to previous years. The percentage of male arrestees in Fulton county testing positive for opiates was stable from 2007 to 2008, while self reports of ever receiving treatment for heroin use decreased, from 72.1 percent in 2007 to 47.5 percent in 2008. Purity levels of Southwest Asian (SWA) heroin increased from 2007 to 2008. Purity levels for South American (SA) heroin represented a slight increase from 2007. The price of SWA increased from 2007 to 2008 while the price of SA decreased. **Alprazolam** levels remained consistent for treatment admissions at 1.1 percent in the first half of 2009, compared with 0.7 percent in 2008. NFLIS data also indicated consistency across years for alprazolam, with 249 seizures in the first half of 2008 and 267 seizures in the same period in 2009. Indicators of **oxycodone** showed an increase in use in the Atlanta area. Treatment admissions doubled in the first half of 2009, to 2.1 percent, compared with 1.0 percent in 2008. NFLIS data showed a steady increase, from 145 seizures in the first half of 2008 to 230 seizures in the same period in 2009. This pattern was similar for **hydrocodone**, with NFLIS data showing 241 seizures in the first half of 2009, compared with 192 seizures in the first half of 2008. Drug indicators (treatment admissions, NFLIS) suggested that **MDMA** (3,4-methylenedioxymethamphetamine) decreased slightly in 2009, after stabilizing in 2008 from an increase in 2007.

Data Sources: *Treatment data were provided by the Georgia Department of Human Resources. Coverage included all direct providers of treatment services that receive county or State program funds in the 28 counties that comprise metropolitan Atlanta. Data on all client admissions for drug and alcohol treatment—not just clients receiving treatment paid for using public funding*

*sources—are included in the data set. This report presents admissions data from January through June 2009—the most recent data available—and makes comparisons with percentages from prior years. **Forensic laboratory data** were provided by NFLIS, Drug Enforcement Administration, for the first half of 2009. While these data are described, they can only be compared with 2007 results due to the establishment of new methodology methods. For purposes of comparison with the previous year, calendar year (CY) 2009 data are extrapolated. **Prison/jail admissions data** were provided by the Georgia Department of Corrections and include CY 2009. **Georgia Crisis and Access Line Call data** were provided by the Georgia Department of Human Resources. Coverage includes all statewide telephone calls for Georgia's single point of entry program, a required step toward seeking substance abuse treatment from a public facility. This report presents call data from July 2006 through November 2008. For comparison, the data for the second half of 2009 are extrapolated. **Arrestee data** were provided by the Arrestee Drug Abuse Monitoring II program and cover male arrestees in the city of Atlanta/Fulton County, GA. There were two facilities in the sample. **Heroin price and purity data** were provided by the Heroin Domestic Monitoring Program, Drug Enforcement Administration.*

Drug Abuse Patterns and Trends in Baltimore, Maryland, and Washington, DC—Update: January 2010

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Overview of Findings: Throughout the Washington, DC, and Maryland region, cocaine, marijuana, and heroin continued to be the primary drug problems in 2009, but the increase in the misuse of prescription drugs seen in 2007 also continued into 2008 and 2009. The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) reported that cocaine and marijuana were the most frequently seized and identified drugs in the region. The third most frequently found drug in the Maryland part of the HIDTA region was heroin, while in Washington, DC, it was PCP (phenylclidine). While other parts of the country have seen shifts in the use of methamphetamine, its use remained low throughout Maryland and Washington, DC, and was confined to isolated communities in the DC District. The percentage of adult and juvenile offenders in Washington, DC, testing positive for amphetamines remained considerably lower than for other drugs and decreased in 2008 and 2009.

Updated Drug Abuse Trends and Emerging Patterns: In Washington, DC, in 2009, **cocaine/crack, marijuana, and heroin** continued to be the primary illicit drug problems. Cocaine remained one of the most serious drugs of abuse, as evidenced by the fact that more adult arrestees and more items seized tested positive for cocaine than for any other drug. However, the percentage of adult arrestees testing positive for both cocaine and PCP was decreasing. In the first 10 months of 2009, 29.2 percent of adult arrestees tested positive for cocaine, and approximately 9 percent tested positive for opiates and/or PCP. More seized items tested positive for cocaine (39.7 percent) in the first 6 months of 2009 than for any other drug, as reported by the National Forensic Laboratory Information System (NFLIS). The total number of overdose deaths decreased from 119 in 2005 to 90 in 2007. They were also more likely to be related to cocaine (65.6 percent) than to any other drug. During the first 10 months of 2009, juvenile arrestees were more likely to test positive for marijuana (52.4 percent) than for any other drug, but the percentage appeared to be

decreasing. The percentage testing positive for cocaine also continued to decrease in the first 10 months of 2009 (from 3.5 percent in 2005 to 0.7 percent in 2009). The percentage testing positive for PCP also decreased from 2008 to 2009 (2.8 to 1.5 percent) after holding steady from 2007 to 2008. In *Maryland*, there were 32,301 primary admissions to certified treatment programs in the first 6 months of 2009. They most frequently involved **alcohol, heroin, marijuana, crack, and other cocaine**. Cocaine and marijuana accounted for nearly three-quarters of the positive items tested through NFLIS during the first 6 months of 2009. Approximately one in five items tested were positive for heroin, and nearly all of these items (89.8 percent) were from Baltimore. The number of drug intoxication deaths in Maryland decreased approximately 13 percent from 2007 to 2008 and appeared to be continuing to decrease in 2009. **Narcotics** (heroin, methadone, oxycodone, fentanyl, and other) were the most frequently identified drugs in drug abuse deaths in 2009, and approximately one-third of these deaths occurred in Baltimore.

Data Sources: *Drug seizure data* were provided by NFLIS and the Drug Enforcement Administration for the first half of 2009 and by the Washington/Baltimore HIDTA. *Heroin cost data* were obtained from the Heroin Domestic Monitor Program, and *data on the retail distribution of selected prescription opioid medications* were obtained from the Automation of Reports and Consolidated Orders System Retail Drug Summaries. *Mortality data* were obtained from the Office of the Chief Medical Examiner, Washington, DC. *Data on substance abuse by youth* were adapted by the Center for Substance Abuse Research from the Maryland State Department of Education's 2007 Maryland Adolescent Survey and the Youth Risk Behavior Survey. *Adult and juvenile arrestee data* were adapted from information obtained from the District of Columbia Pretrial Services Agency. *Treatment admissions data* for Baltimore City were obtained from the Alcohol and Drug Abuse Administration State of Maryland Automated

Record Tracking system and for Washington, DC, from the Treatment Episode Data Set.

Drug Abuse Patterns and Trends in Greater Boston—Update: January 2010

Daniel P. Dooley

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Overview of Findings: Cocaine and heroin continued as the dominant drugs of abuse in Boston during this reporting period. Cocaine figured prominently among drug-related deaths, emergency department (ED) visits, drug arrests, and drug laboratory samples derived from drug arrests. Heroin continued to dominate as the primary drug in treatment and was cited most often among calls to the substance abuse helpline. Marijuana, other opiates/synthetics (including oxycodone), and benzodiazepines were all present at more moderate levels. Methamphetamine and other “club drugs” remained at relatively low levels overall.

Updated Drug Abuse Trends and Emerging Patterns: In Boston, most cocaine indicators were decreasing slightly, but remained at very high levels, compared with other drugs. Cocaine figured in 44 percent of all drug-related deaths in 2007. Cocaine was the most prominent drug among identified drugs in ED visits. The proportion of estimated cocaine-involved ED visits decreased slightly, from 30 percent in 2007 to 27 percent in 2008. The proportion of primary cocaine treatment admissions remained stable from fiscal year (FY) 2003 to FY 2009 (between 7 and 8 percent), but the proportion of cocaine calls to the helpline decreased, from 22 percent in FY 2006, to 19 percent in FY 2008, to 15 percent in FY 2009. The proportion of Class B drug arrests (mainly cocaine) decreased slightly, from 46 percent in 2007 to 42

percent in 2008. Cocaine drug laboratory samples decreased, from 33 percent in 2007 to 28 percent in 2008. **Heroin** abuse indicators were stable or increased slightly and remained at extremely high levels in Boston. Heroin and other opioids figured in 530 (76 percent) area drug-related deaths in 2007. Of these, 12 percent were single-drug deaths. In 2008, heroin was identified among 25 percent of estimated drug-involved ED visits. In FY 2009, 51 percent ($n=10,123$) of all treatment admissions cited heroin as the primary drug problem. After having steadily increased from 35 percent in FY 1998 to 49 percent in FY 2005, the proportion of primary heroin treatment admissions remained fairly stable at between 50 and 51 percent from FYs 2006 to 2009. The proportion of heroin calls to the substance abuse helpline increased slightly, from 31 percent in FY 2007 to 34 percent in FY 2009. The level of Class A drug arrests (mainly heroin) increased, from 15 percent in 2007 to 18 percent in 2008. The level of heroin drug laboratory samples rose, from 9 percent in 2007 to 12 percent in 2008. The Drug Enforcement Administration (DEA)'s most recent data (October and January 2009), revealed that a bag of heroin cost between \$8 and \$50, with an average purity level at 17 percent, on the streets of Boston. The price per milligram pure increased, from \$1.37 in 2007 to \$1.62 in 2008. Indicators for **other opiates/opioids** were at moderate levels and were mainly increasing. The estimated number of ED visits involving opiates/opioids increased significantly by 42 percent, from 4,164 in 2006 to 5,919 in 2008. From FYs 2006 to 2008, there were approximately 650 to 660 other opiates/synthetics treatment admissions per year. The number increased to 851 in FY 2009, the highest number recorded in more than 10 years. The proportion of other opioid helpline calls increased, from 14 percent in FY 2008 to 17 percent in FY 2009. The proportion of oxycodone drug laboratory samples remained stable for 7 years (2002 to 2008) between 2 and 3 percent. **Marijuana** indicators were mixed (either stable or increasing) at varied levels. The estimated number of marijuana ED visits increased by 16 percent from 2007 to 2008. The proportion of marijuana treatment admissions

edged up, from 3 percent in FY 2007 to 5 percent in FY 2009. From FYs 2008 to 2009, the proportion of marijuana helpline calls remained at 4 percent. Class D drug arrests (mainly marijuana) accounted for 35 percent of total drug arrests in both 2007 and 2008. This proportion remained stable at between 33 and 37 percent from 2002 to 2008. The proportion of marijuana drug laboratory samples remained at 35 percent from 2007 to 2008. **Methamphetamine** abuse levels remained low in Boston, representing less than 1 percent of all estimated ED visits, treatment admissions, helpline calls, and drug laboratory samples. The number of primary admissions for methamphetamine totaled 72 in FY 2009, 59 admissions in FY 2008, and 29 admissions in FY 2007. The number of methamphetamine calls to the helpline from FY 2000 to FY 2009 totaled fewer than 25 for each year. Methamphetamine drug laboratory samples totaled 35 in 2008, 26 in 2007, and 36 in 2006. **Benzodiazepine** abuse in Boston remained at moderate levels with indications it may be increasing. In 2007, one in five (20 percent) of drug-related deaths involved at least one benzodiazepine. In 2008, 30 percent of the NMUP (nonmedical use of pharmaceuticals) estimated drug-related ED visits involved benzodiazepines. The estimated number of benzodiazepine-involved ED visits increased by 30 percent over 2 years from 2006 to 2008. Klonopin® (clonazepam) was identified in more than one-half of the ED visits with an identified benzodiazepine. The proportion of benzodiazepine calls to the helpline was 4 percent in FY 2008 and 6 percent in FY 2009. Of benzodiazepine calls, Klonopin® (clonazepam) was mentioned most often. Clonazepam and alprazolam ranked sixth and seventh among NFLIS drug laboratory samples in the first half of 2009.

Data Sources: *Drug-related deaths data for a seven-county Boston metropolitan area composed of five Massachusetts counties, including Essex, Middlesex, Norfolk, Plymouth, Suffolk, and two New Hampshire counties, including Rockingham and Strafford, were provided by the Drug Abuse Warning Network (DAWN), Office of*

*Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), 2007 (08/2008 update). **ED drug visit estimates** for 2004–2008 for a seven-county Boston metropolitan area composed of five Massachusetts counties, including Essex, Middlesex, Norfolk, Plymouth, Suffolk, and two New Hampshire counties, including Rockingham and Strafford, were provided by DAWN, OAS, SAMHSA (files produced 11/24/09 and 12/1/09). **State-funded substance abuse treatment admissions data** for the Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (Community Health Network Area [CHNA] 19), for FYs 1998 through 2009 (July 1, 1997, through June 30, 2009) were provided by the Massachusetts Department of Public Health (DPH), Bureau of Substance Abuse Services. **Helpline data** provided information on drug mentions during calls received by the Massachusetts Substance Abuse Information and Education Helpline for a Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19) for FYs 2000 through 2009. **Drug arrest data** for the city of Boston for 2002 through 2008 were provided by the Boston Police Department, Drug Control Unit and Office of Research and Evaluation. A new Massachusetts law decriminalizing possession of less than an ounce of marijuana took effect January 1, 2009, and will impact future drug arrest indicators. **Forensic laboratory data** for the Boston CHNA 19 for 1998 through 2008 were provided by the Massachusetts DPH Drug Analysis Laboratory in Amherst, Massachusetts. These Boston-area drug sample counts differ from drug sample counts derived from the National Forensic Laboratory Information System and do not include samples analyzed at the Worcester County or State Police laboratories. **Drug price and purity information** was provided by DEA New England Field Division, January and October 2009.*

Drug Abuse Patterns and Trends in Chicago—Update: January 2010

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Overview of Findings: Cocaine, heroin, and marijuana continued to be the major substances of abuse for Chicago and the surrounding metropolitan area in 2009. Major indicators suggested that levels of cocaine, heroin, and marijuana abuse were high and steady. There were few noteworthy changes that occurred for the reporting period. Drug Enforcement Administration (DEA) Heroin Domestic Monitor Program (HDMP) data indicated that heroin purity continued to increase in 2008, to the highest levels of the decade.

Updated Drug Abuse Trends and Emerging Patterns: Most indicators of drug use were collected for the calendar or fiscal year 2009 or, if not available, for 2008. Levels of **cocaine** abuse continued to be high relative to other drugs, and indicators were stable in 2009. Weighted estimates from Drug Abuse Warning Network (DAWN) for calendar year (CY) 2008 showed that 40 percent of total emergency department (ED) visits for major substances of abuse (excluding alcohol) involved cocaine. Cocaine constituted 22 percent of all drug items identified by the National Forensic Laboratory Information System (NFLIS) in the first half of 2009. Wholesale price ranges for powder cocaine reported by the National Drug Intelligence Center (NDIC) increased slightly, ranging from \$17,000–\$25,000 in 2007 per kilogram to \$25,000–\$31,000 per kilogram in December 2008. Ethnographic reports suggested that availability of powder cocaine remained moderate on the Chicago streets and that the quality of crack cocaine may have declined. **Heroin** levels of abuse were also high relative to other drugs and stable in the first half of 2009. Weighted estimates, accessed from DAWN for CY 2008, showed that 31 percent of total ED estimated visits for major substances

of abuse (excluding alcohol) involved heroin. The average purity of heroin, as reported by the DEA, was 22.4 percent in 2007 and 23.8 percent in 2008, the highest level since 1999. Major indicators of drug use suggested that **marijuana** abuse was also high and stable in 2008. Weighted estimates from DAWN for CY 2008 showed that 16 percent of ED visits for major substances of abuse (excluding alcohol) were marijuana involved. Marijuana was the predominant drug item analyzed by NFLIS for the first half of 2009, consisting of 58 percent all drugs. Hydroponic marijuana continued to be available in Chicago, priced significantly higher than nonhydroponic marijuana. Among **prescription drugs**, those most often cited in ethnographic reports as being used without a prescription were Xanax®, Vicodin®, Klonopin®, clonidine, and methadone. **MDMA** (3,4-methylenedioxymethamphetamine) remained popular in low-income African-American neighborhoods. Primary users were in their teens and twenties. **Buprenorphine** became the fourth most commonly seized prescription drug identified by NFLIS in the first half of 2009. Suboxone® was the most commonly reported form of buprenorphine; it was typically used without a prescription to avoid withdrawal, or to better manage an addiction to heroin. **Drug injection** by young African-Americans was rare. New injection drug users were likely to be White and to reside in suburban Chicago. **HIV/AIDS Update:** The prevalence and incidence of human immunodeficiency virus (HIV) infection among injection drug users (IDUs) has declined markedly, compared with the 1980s and 1990s. HIV prevalence among injecting and noninjecting drug users was converging in low-income Chicago neighborhoods.

Data Sources: *Weighted ED drug visit data for 2004–2008 were provided by DAWN, administered by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Criminal justice data were available from the Illinois Criminal Justice Information Authority (ICJIA), which collects, maintains, and updates a variety of criminal justice data to support its research and evaluation efforts. ICJIA regularly*

publishes criminal justice research, evaluation reports, and statistical profiles. ICJIA's drug arrest data for 2005–2006, and the 2004 special report on methamphetamine trends in Illinois, were reviewed. Price and purity data for heroin for 1991–2008 were provided by the DEA's HDMP. The Illinois State Police, Division of Forensic Science, provided purity data on drug samples for 2008. Drug price data are reported from the June 2008 and December 2008 reports of National Illicit Drug Prices by the NDIC. Data from NFLIS for the first half of 2009 were used to report on drugs items identified in forensic laboratories after being seized by law enforcement in Chicago. Ethnographic data on drug availability, prices, and purity are from observations and interviews conducted by the Community Outreach Intervention Projects, School of Public Health, University of Illinois at Chicago. HIV prevalence data for 2005–2009 were derived from the NIDA-funded "Sexual Acquisition and Transmission of HIV—Cooperative Agreement Program" (SATH-CAP) study in Chicago (U01 DA017378). Respondent-driven sampling was used at multiple sites in Chicago to recruit men and women who use "hard" drugs (cocaine, heroin, methamphetamine, or any illicit injected drug), men who have sex with men regardless of drug use, and sex partners linked to these groups. All participants (n=4,321) completed a computerized self-administered interview and were tested for HIV, syphilis, chlamydia, and gonorrhea. SATH-CAP data were compared with findings from earlier studies of IDUs sponsored by NIDA and the CDC.

Drug Abuse Patterns and Trends in Cincinnati (Hamilton County)—Update: January 2010

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Overview of Findings: The predominant drug issues in Cincinnati continued to involve both cocaine/crack cocaine and marijuana as primary drugs of abuse. Cocaine indicators decreased somewhat from a relatively high to moderate level for the first half of 2009, compared with 2008 data. Indicators for marijuana in the Cincinnati region were consistently reported at high levels, with a leveling off seen during the first half of 2009, compared with 2008 data sources. Marijuana as a primary drug of abuse accounted for 45.5 percent of treatment admissions, excluding alcohol, and it represented more than 44 percent of items submitted for forensic analysis for the Cincinnati area. Indicators for heroin were at a moderate level, with a rise in some indicators during 2009 from the previous year. The number of exposure cases reported to poison control involving heroin increased by 32 percent in 2009 over 2008. Thirteen percent of heroin exposure cases reported to poison control were suspected to be adulterated with clenbuterol. Methamphetamine indicators continued to be low relative to other drugs in Cincinnati. MDMA (3,4-methylenedioxymethamphetamine) indicators remained low to moderate in Cincinnati, with some slight increase noted during 2009. Abuse of prescription drugs, specifically benzodiazepines and opioid narcotics, continued to be an increasing drug issue in Cincinnati. The seizure of counterfeit alprazolam in the region contributed to the growing issue surrounding pharmaceutical drug abuse. Calls to poison control involving buprenorphine-containing pharmaceuticals increased from 2008 to 2009, with some increase in cases suspected as intentional abuse of the drug.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine/crack cocaine remained a primary drug of abuse reported during admission to treatment programs, accounting for nearly 21 percent of admissions, excluding alcohol, during the first half of 2009. The Cincinnati Regional Enforcement Narcotics Unit (RENU) removed a combined total of more than 29,000 grams of cocaine/crack cocaine during 2009. Indicators for cocaine/crack dropped from high to

moderate during the first half of 2009, compared with the previous year. There were 25 percent fewer calls recorded by poison control in 2009, compared with 2008. Cocaine and crack cocaine seizures submitted to the Drug Enforcement Administration (DEA) laboratory for analysis for the first half of 2009 revealed tetramisole (levamisole) impurities in 67 percent of the analyzed samples. **Marijuana** dominated all other reported drugs as primary among treatment admissions, accounting for nearly 45.5 percent of admissions, excluding alcohol, during the first half of 2009. While marijuana availability and use remained high across the Cincinnati region, indicators pointed to a leveling off at a high level. **Heroin** remained at a moderate level, with indicators pointing to an increase for the Cincinnati region for the reporting period in 2009, compared with 2008. Treatment admissions for primary heroin abuse were not delineated from other opiate/opioid admissions, but the number of overall heroin and opioid admissions increased to more than 23 percent of total admissions, excluding alcohol. The number of items submitted in the first half of 2009 for forensic analysis and identified as heroin increased to 9.6 percent, from 5.7 percent the previous year. Poison control data showed a 32-percent increase in reported human heroin exposure cases in 2009. Adulteration with clenbuterol was suspected in 13 percent of poison control cases, based on symptoms reported during admission. Use of **methamphetamine** in Cincinnati has remained low, with little indication of change noted during 2009. **MDMA** availability and use in Cincinnati during 2009 remained at a low to moderate level, with some indication of a slight increase in items seized and identified as MDMA by NFLIS. **Prescription narcotics** containing either oxycodone or hydrocodone remained the most prevalent of the opioid products abused in Cincinnati. In addition, qualitative indicators pointed to high availability, but indicators remained stable in the 2009 reporting period, compared with 2008. Poison control data on oxycodone and hydrocodone showed some decrease in human exposure cases reported during 2009, compared with 2008. Abuse of methadone

appeared to be leveling out. The most frequent benzodiazepine abused continued to be alprazolam, according to both users and law enforcement. Human exposure cases involving alprazolam and clonazepam reported to poison control remained relatively stable during 2009, compared with 2008. Counterfeit alprazolam was seized by the Warren County Drug Task Force in September 2009. Phenazepam, a drug manufactured in Russia, was the primary substituted drug in the adulterated tablets seized. A total of 343 tablets were seized from a shipment of 1,000 tablets, resulting in poison control directing all drug identification calls in September and beyond to the crime laboratory for definitive analysis. Poison control fielded 137 drug identification calls with the imprint found on the counterfeit alprazolam from September through December 2009. **Emerging Patterns:** Indicators for buprenorphine abuse, using poison control data, continued to show growing numbers of both human exposure calls as well as drug identification calls. The total number of human exposure calls rose by 28 percent in 2009 over the previous year, with 34 percent of the calls involving intentional misuse or abuse of buprenorphine. Drug identification calls to poison control are often used as indicators of pharmaceutical diversion.

Data Sources: *Medical Examiner data* were obtained by the Hamilton County Coroner's Office for drug-related deaths for the first half of 2009, for comparison with death data from 2006–2008. Data resulted from positive toxicology evidence of drug or alcohol use found in decedents. Cases were classified as accidental, suicide, or homicide. Drug or alcohol findings were not necessarily recorded as cause of death. **Qualitative data** came from focus group interviews conducted for the Ohio Substance Abuse Monitoring Project, funded by the Ohio Department of Alcohol and Drug Addiction Services through a grant to Wright State University. **Drug purity data** were provided by the Drug Enforcement Administration (DEA), Cincinnati Resident Office, for January to December 2009. **Treatment data** were provided by the Hamilton County Mental Health and Recovery

*Services Board for fiscal years 2006 and 2007, calendar year (CY) 2008, and the first half of CY 2009. Data were provided for publicly funded treatment programs within Hamilton County only. Primary drug of use at admission was determined through billing data submitted by reporting agencies. Data methodology capture differed from previous reporting periods and provided for direct comparison between CY 2008 and the first half of 2009. Data were captured by group classification and not necessarily by specific drug type or route of administration. **Poison control data** were provided by the Cincinnati Drug and Poison Information Center for CYs 2006 through 2009. There are two call "types" recorded—either drug information, or actual exposure to a product. Most exposures involved intentional abuse/misuse/suspected suicide, but all were captured in the data set. All exposure cases are for human cases only; animal cases were excluded, as were "confirmed" nonexposure cases. **Drug seizure data** were provided by the RENU. **Forensic laboratory data** were provided by the National Forensic Laboratory Information System, DEA, for the first half of 2009. **Additional drug seizure data** were provided by the Warren County Drug Task Force. **Methamphetamine clandestine laboratory data** were provided by the Ohio Bureau of Criminal Identification & Investigation.*

Drug Abuse Patterns and Trends in Colorado and the Denver/Boulder Metropolitan Area—Update: January 2010

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Overview of Findings: Ranking high in relation to other drugs and with mostly stable or increasing trends, marijuana continued to be a major drug of abuse in Colorado and the Denver/Boulder

metropolitan area, based on data on treatment admissions, hospital discharges, law enforcement drug testing, and estimated emergency department (ED) visits. Cocaine, ranking among the top drugs in frequency of use and with mostly downward and some stable trends, continued to be at or near the top of Colorado and Denver/Boulder area indicators, including treatment admissions, hospital discharges, estimated ED visits, drug-related mortality, poison control center calls, and law enforcement drug testing. Among Colorado and Denver/Boulder area indicators, methamphetamine presented with mostly downward and stable trends, based on a large but declining proportion of treatment admissions, a significant decrease in methamphetamine-involved ED visits, declining laboratory seizures, and relatively small proportions of hospital discharges and death mentions. Heroin abuse indicators, although being relatively low in proportionate share compared with other drugs, appeared to be on the rise, based on treatment admission and hospital discharge data. Statewide and in the Denver/Boulder area, opioids other than heroin were a small but increasing percentage of treatment admissions. Other opioids also represented a substantial proportion of estimated ED visits, hospital discharges, and drug-related mortality. Beyond abuse of illicit drugs, alcohol remained Colorado's most frequently abused substance and accounted for the most treatment admissions, ED reports, poison center calls, drug-related hospital discharges, and drug-related mortality.

Updated Drug Abuse Trends and Emerging Patterns: Excluding alcohol, **marijuana** continued to be the primary drug of abuse statewide and in the greater Denver area. During the first half of 2009, admissions for marijuana represented 38 percent of total drug treatment admissions in Colorado and accounted for 39 percent of Denver-area admissions. There was more than a 200-percent statistically significant increase in the Denver metropolitan area weighted

marijuana-involved Drug Abuse Warning Network (DAWN) ED visit rate from 2004 (50.4) to 2008 (151.3); the rate in 2007 was 146.9. Marijuana ranked first (excluding alcohol) in 2008 Colorado hospital discharges ($N=4,256$; rate per 100,000=85); both the number and rate of discharges increased from 2007 ($N=3,706$; rate per 100,000=75). Also, marijuana/cannabis was the second most common drug seized and identified by forensic laboratories in the first half of 2009 in Arapahoe, Denver, and Jefferson Counties, based on National Forensic Laboratory Information System (NFLIS) data. Federal drug seizures for marijuana across Colorado, after being relatively stable from 2003 (444.1 kilograms) to 2006 (656.8 kilograms), increased to 24,089.2 kilograms in 2008. There have been several large-scale outdoor marijuana grow operations seized in Colorado National Forests in recent months. The Drug Enforcement Administration (DEA) reported that "Mexican nationals are going onto government property," something they had previously only seen in California. As of January 2009, Denver had more medical marijuana dispensaries per capita than any other city in the United States and has been named "America's Cannabis Capital" by the National Organization for the Reform of Marijuana Laws. The demand for medical marijuana in Colorado has grown so fast that it has outstripped the production of legal "grow" operations and is now probably being supplied by international drug cartels, according to some local sheriffs and agents from the DEA.¹¹ This is a very recent trend and the legalities and implications of medical marijuana will need continued monitoring. **Methamphetamine**, which accounted for the next highest proportion of treatment admissions statewide (excluding alcohol), overtook cocaine admissions in the first half of 2003. Methamphetamine admissions continued to increase and peaked during the second half of 2005 (at 33 percent). Methamphetamine admissions decreased slightly to 31 percent during the first half of 2006 and remained stable through 2007, but they then

¹¹McPhee, M., Barbatelli, V. (2009, October 21). Some think cartels help supply medical marijuana in Colorado. *The Denver Post* (Denver, CO), Retrieved October 23, 2009 from Web site: <http://www.denverpost.com>.

declined in the first half of 2009 (to 24 percent). In greater Denver, methamphetamine represented 22 percent of first half of 2006 admissions and 23 percent in the first half of 2007, but such admissions then declined to just 18 percent in the first half of 2009. The weighted methamphetamine DAWN ED visit rate per 100,000 for the Denver metropolitan area fell from 49.9 in 2007 to 35.5 in 2008. This was a statistically significant decrease of 27 percent. Methamphetamine was the third most common drug seized and identified by forensic laboratories in the first half of 2009 in Arapahoe, Denver, and Jefferson Counties, based on NFLIS data. Federal drug seizures for methamphetamine across Colorado increased each year from 2003 (14.8 kilograms) to 2006 (50.3 kilograms). In 2007, Federal drug seizures for methamphetamine sharply declined (8 kilograms), but they increased in 2008 (26.4 kilograms). Likewise, methamphetamine laboratory seizures in Colorado declined from 345 in 2003 to 33 in 2008. **Cocaine** admissions (excluding alcohol) statewide remained mostly stable (between 18 and 22 percent) from 2002 through 2008 and declined to 16 percent in the first half of 2009. Denver-area primary cocaine admissions decreased from 24 percent in the first half of 2007, to 22 percent in the first half of 2008, to 18 percent in the first half of 2009. The weighted cocaine-involved ED visit rate per 100,000 for the Denver metropolitan area decreased, from 204.9 in 2007 to 168.1 in 2008, which represents a statistically significant decrease of 16 percent. Excluding alcohol, cocaine ranked third (behind marijuana and opioids) in 2008 Colorado substance abuse-related hospital discharges ($N=3,533$; rate per 100,000=71), but both the number and rate of discharges decreased from 2007 ($N=3,980$; rate per 100,000=81). Cocaine was the second most common drug (excluding alcohol and behind other opioids) in Colorado death mentions in 2008, at a rate of 3.3 per 100,000 for the State; this is down slightly from 3.9 per 100,000 in 2007. Continuing the scenario of cocaine dominance in the greater Denver area, cocaine was the most common drug submitted for testing by law enforcement in the first half of 2009 in Arapahoe, Denver, and

Jefferson Counties, based on NFLIS data. Federal drug seizures for cocaine across Colorado, after decreasing from 65.5 to 36 kilograms from 2003 to 2004, increased substantially in 2005 (131.5 kilograms) and 2006 (135.1 kilograms) but declined sharply in 2007 (44.0 kilograms). Federal drug seizures for cocaine increased slightly in 2008 (to 52.6 kilograms). In the first half of 2009, **heroin** ranked fourth in both statewide and greater Denver treatment admissions, representing 9 and 13 percent of admissions (excluding alcohol), respectively. Although heroin was not among the most common drugs found in Colorado death mentions, it remained fairly stable from 2005 to 2008, at a rate of 0.9 per 100,000. Heroin lagged far behind cocaine, marijuana/cannabis, and methamphetamine among drugs submitted for testing by law enforcement in the first half of 2009 in Arapahoe, Denver, and Jefferson Counties based on NFLIS data. Only small quantities of heroin were seized in Colorado, ranging from 2.5 to 4.6 kilograms from 2003 to 2008. The DEA reported that, based on heroin samples purchased through the 2008 Heroin Domestic Monitor Program (HDMP), there have been no significant changes in the price and purity of heroin in Denver in recent years. **Other opioids (i.e., prescription opioids, narcotic analgesics)** ranked fifth in both statewide and greater Denver treatment admissions (excluding alcohol), accounting for 8.7 and 7.8 percent of admissions, respectively, in the first half of 2009. Statewide, other opiate admissions have gradually risen from the second half of 2004 (4.1 percent) to the first half of 2009 (8.7 percent), with the biggest increase from the first half of 2008 (6.7 percent) to the first half of 2009 (8.7 percent). Similarly, in the greater Denver area, primary opioid admissions have started to climb from 4.5 percent in the first half of 2007, to 6.2 percent in the first half of 2008, to 7.8 percent in the first half of 2009. For the first half of 2009, oxycodone and hydrocodone accounted for approximately two-thirds of all unweighted narcotic analgesic ED reports. The Denver metropolitan weighted ED visit rate per 100,000 for narcotic analgesics increased from 87.5 in 2007 to 104.4 in 2008. This represents a statistically significant

22-percent increase in weighted estimates of DAWN ED visits involving narcotic analgesics in 2008. This rate has more than doubled since 2006. Excluding alcohol, opioids ranked second in 2008 Colorado substance abuse-related hospital discharges ($N=3,890$; rate per 100,000=78); both the number and rate of discharges increased from 2007 ($N=3,453$; rate per 100,000=70). Other opioids were the most common type of drug (excluding alcohol) in Colorado death mentions in 2008, at a rate of 5.9 per 100,000 for the State, which was down slightly from 6.4 per 100,000 in 2007. Other opioids have been the most common drugs found in Colorado drug-related deaths from 2005 to 2008. Oxycodone (1.9 percent) and hydrocodone (1.3 percent) were in the top 10 drugs analyzed in the first half of 2009 in Arapahoe, Denver, and Jefferson Counties, based on NFLIS data. **Benzodiazepines** (“benzo’s,” barbiturates, clonazepam, other sedatives, and tranquilizers) represented 1 percent of State treatment admissions in the first half of 2009. There was a statistically significant increase (30 percent) in weighted benzodiazepine-involved DAWN ED reports in the Denver metropolitan area from 2006 to 2008. **MDMA** (3,4-methylenedioxymethamphetamine) accounted for only 0.4 percent of State treatment admissions (excluding alcohol) in the first half of 2009. There was a 30-percent (statistically significant) increase in weighted MDMA-involved DAWN ED visits in the Denver metropolitan area from 2007 to 2008. The DEA states that Canada is the source for most MDMA encountered in Colorado. **BZP** (1-benzylpiperazine) was not identified by any of the most common drug indicators, but may become a drug of interest in the future, especially in combination with MDMA and **TFMPP** (1-3-(trifluoromethylphenyl)piperazine). Recently, the DEA reported confiscating a vehicle transporting 4,000 pills (alleged to be MDMA) from California to Colorado. However, after being analyzed, it was determined the pills were actually BZP and TFMPP. **HIV/AIDS Update:** Cumulative acquired immunodeficiency syndrome (AIDS) data through September 2009 indicated cases related to injection drug use remained stable.

Data Sources: *Treatment data* were provided by the Colorado Department of Human Services, Division of Behavioral Health (DBH). Data from client admissions to all DBH-licensed treatment providers from January–June 2009 were included in the data set. **Unweighted ED DAWN Live! data** from the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA) provided drug reports in ED visits occurring for January–June 2009. No comparisons with earlier time periods or discussions of trends can be done with unweighted data. Data in this report reflect cases that were received by DAWN as of December 10, 2009. Unweighted DAWN data are reported for the Denver area only. **Weighted ED DAWN data** from OAS, SAMHSA, were available to report drugs involved in ED visits occurring 2004–2008 (output produced 9/6/2009). Rates per 100,000 were based on U.S. Census, County-Level Population Estimates (CPOP file). **Forensic laboratory data** were provided by NFLIS, DEA, for the first half of calendar year (CY) 2009 (January–June). While the NFLIS data are described, they cannot be compared with earlier data to establish trends, as a new methodology renders them not comparable. **Hospital discharge data** were obtained from the Colorado Department of Public Health and Environment and from the Colorado Hospital Association. These data represent CY 2008. **Death data** were obtained from the Colorado Department of Public Health and Environment. **Poison control center call data** were obtained from the Rocky Mountain Poison Control Center and represent CY 2008. **Information on drug seizure quantities** was obtained from the standard DEA report, State Facts: Colorado 2008. Data were for CY 2008. **Heroin drug price and purity data** came from the DEA’s 2008 HDMP report published in October 2009. **Intelligence and qualitative data** were obtained from a questionnaire developed by the Denver Office of Drug Strategy and sent in September 2009 to law enforcement, treatment, research, public health, and street outreach agencies. **Intelligence data and information** were also obtained from the National Drug Intelligence Center, U.S. Department of Justice, High

Intensity Drug Trafficking Area Program, Office of National Drug Control Policy, Rocky Mountain Region, Drug Market Analysis, March 2009. AIDS data were obtained from the Colorado Department of Public Health and Environment (HIV/STD Surveillance Program Disease Control and Environmental Epidemiology).

Drug Abuse Patterns and Trends in Detroit, Wayne County, and Michigan—Update: January 2010

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Overview of Findings: Heroin and cocaine were the two major drugs of abuse in the Detroit/Wayne County area in 2009, and marijuana was widespread. Few changes were noted since the June 2009 report; cocaine treatment admissions continued to decline as a proportion of total admissions, and heroin treatment admissions continued to increase. Crack cocaine continued to be the dominant form of cocaine found in the city of Detroit. Treatment admissions for marijuana as the primary drug of abuse may be expanding to include older adults and more females. Criminal justice involvement in marijuana admissions, although present in more than one-half the admissions and at a higher level than that for other primary drugs of abuse, may be declining. The percent of treatment admissions who were homeless dropped in fiscal year (FY) 2009 to 22.4 percent from a high of 28.7 percent in FY 2008. Levamisole continued to be detected in cocaine at the Medical Examiner's (ME) office. Calls to the Poison Control Center for intentional human consumption of cocaine and ecstasy declined; calls for heroin increased. BZP (1-benzylpiperazine) climbed in ranking of volume of specific drugs detected among items seized.

Updated Drug Trends and Emerging Patterns: Treatment admissions with **cocaine** as the primary drug accounted for 19 percent of Detroit publicly funded admissions in FY 2009, down from 24.1 percent in FY 2008; 92 percent of these admissions were for crack cocaine. Of the cocaine admissions, 57.6 percent were male; 90.6 percent were African-American; and 83.6 percent were older than 35. In the first half of 2009, the Wayne County ME reported 141 deaths involving cocaine, the highest number for all drugs. Levamisole continued to be detected in many decedents (84 in first half of 2009, compared with 133 for all of 2008). The number of calls to the Poison Control Center for intentional human consumption declined, from 159 in 2008 to an annualized count of 126 in 2009. Unweighted emergency department (ED) cases from Detroit showed a continued decline in the proportion of major substance cases with cocaine in the first half of 2009, compared with previous years. The weighted ED cocaine rate per population in the five-county Detroit area also showed a significant decline from 2007 to 2008 for total population, and for both genders. A focus group of law enforcement officials reported little change in cocaine trends during the last 6 months of 2009, with a possibility of increased supply, compared with early 2009. Cocaine ranked second in volume of drug items seized in Wayne County, according to the National Forensic Laboratory Information System (NFLIS). In FY 2009, treatment admissions with **heroin** as the primary drug increased to 36 percent of the publicly funded admissions, from 31.7 percent in FY 2008; 62.4 percent were male; 83.2 percent were African-American; and 90.5 percent were older than 35. In FY 2009, compared with FY 2008, White heroin treatment clients continued to have a younger mean age and were more likely to inject heroin than African-American heroin treatment clients: 37.6 versus 50.8 years, and 71.4 versus 33.6 percent. In the first half of 2009, the Wayne County ME reported an annualized 270 deaths involving heroin, an increase from 224 in 2008. Calls to the Poison Control Center about intentional use of heroin by humans increased in the last half of 2009, compared with

the first half of 2009 and 2008. It ranked third in NFLIS for Wayne County. Treatment admissions with **marijuana** as the primary drug appeared to be stable in FY 2008, at 14.6 percent of all admissions, compared with 14.2 percent in FY 2008. Of these admissions, the percentage of males declined from 71.8 to 64.3 percent; 91.4 percent were African-American; and the proportion younger than 18 declined from 38.7 to 29.9 percent. There was criminal justice involvement in 56.3 percent of the marijuana admissions in FY 2009, compared with 65.4 percent in FY 2008. Marijuana ranked first in NFLIS for Wayne County. A focus group of law enforcement officials reported not yet seeing the impact of the Medical Marijuana Act of 2008. The indicators for **methamphetamine** remained low. It dropped to ninth (from eighth) in volume of drug items seized and identified in Wayne County according to NFLIS. **Ecstasy** use was still evident in ED and ME reports, but the number of calls to the Poison Control Center continued to decline from the peak in 2004. The Poison Control Center reported more calls for **Rohypnol® (flunitrazepam)**. **MDMA** (3,4-methylenedioxymethamphetamine) ranked fifth in NFLIS for Wayne County. For treatment admissions, there was a decline to 22.4 percent in FY 2009 from 28.7 percent in FY 2008 in the proportion of clients who were homeless. Automation of Reports and Consolidated Orders System (ARCOS) data for Michigan showed a decline in the State ranking from 2007 to 2008 for select **narcotic analgesics**: Michigan went from 3rd in the country for grams of codeine per 100,000 population to 4th in the country; 14th to 16th for hydrocodone; 19th to 22nd for methadone (excluding methadone dispensed at treatment programs); and 40th to 44th for oxycodone. The estimated ED rate of nonmedical use for narcotic analgesics per population showed an increase from 2007 to 2008 in the five-county Detroit area for total population and for both genders. People with newly diagnosed human immunodeficiency virus (**HIV**) infection continued to be disproportionately living in the five-county area of Detroit (68 versus 42.4 percent of the total population for Michigan), African-American (65 versus 14.3 percent of

the total population for Michigan), and male (80 percent). Five percent of the people newly diagnosed with HIV infection reported injection drug use, either alone or combined with other high-risk sexual behavior, as a risk behavior.

Data Sources: *Mortality data* came from the Wayne County ME for January–June 2009, with the exception of data used in figure II (section II), which were updated for CY 2009 by the Detroit area representative as of June 2010. **Drug-related crime data** came from a law enforcement officials' focus group conducted by Cynthia L. Arfken, Ph.D. *Poison control data* came from calls made to the Poison Control Center at Children's Hospital of Michigan. **Treatment admissions data** were provided by the Bureau of Substance Abuse and Addiction Services, Division of Substance Abuse and Gambling Services, Michigan Department of Community Health. **ED data** came from the Drug Abuse Warning Network, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. **Forensic laboratory data** were provided by NFLIS. **HIV data** came from Michigan Department of Community Health. **ARCOS data** were obtained from the Drug Enforcement Administration.

Drug Abuse Patterns and Trends in Honolulu and Hawaii—Update: January 2010

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Overview of Findings: The previously reported trend in overall drug use has reversed, with most categories of drug use higher than in the June 2009 report (which was based on data from

the last half of 2008). The cause of this increase after several years of decline is not totally clear. While in the end of year report for 2008 many agencies were claiming responsibility or at least major contribution to the reported decline, this time the room was silent regarding why this might have happened in their data. The street wisdom remains the same as always, “Sometimes it is up, sometimes it is down; now it is ok.”

Updated Drug Abuse Trends and Emerging Patterns: In the first half of 2009, the Hawaii economy finally began to feel the effects of the recession on the mainland and elsewhere: large construction projects began to grind to a halt; reports on closures and layoffs at local businesses were common; there were concerns about balancing the budget in light of several pessimistic reports on revenue forecasts from the State’s Council of Economic Indicators; and news reports from the mainland indicating the depth of the recession taking place all contributed to a mood of pessimism and worry. For the first time in decades, total employment no longer existed in Hawaii, with an unemployment rate a bit above 6 percent. Tourism was starting to decline, as Asia and the mainland began to feel the effects of their own economic changes. In the legislature, the primary focus was on balancing the budget while at the same time negotiating labor contracts for teachers, civil servants, the university, and other State-employed labor. As a result, no legislation of any consequence for substance abuse, crime, and health was passed. Drug prices have remained stable for more than 2 years, regardless of the amount of items seized and identified, number of arrests, or degree of apparent surveillance. The systems of delivery remain in place, and new dealers replace those incarcerated for trafficking. Street reports continued to suggest no shortages of drugs, just a need to know where to look and who to ask. Street reports indicated that methamphetamine and cocaine were readily available, but prices were quite high given the state of the economy. However, as has been seen before in Honolulu, drug prices seem to be relatively inelastic and do not fluctuate much. While confirmation

of these suggestions is not easy, the comments are the result of several independent interviews. The four major drugs identified after seizure or capture and sent for analysis to laboratories participating in the National Forensic Laboratory Information System (NFLIS) shifted from previous reporting periods: methamphetamine was declining; cocaine was rising; marijuana/cannabis was rising; and heroin was declining. The previous reports of MDMA (3,4-methylenedioxyamphetamine) persist and remain stable. **Methamphetamine** was still identified most often, followed by marijuana/cannabis, cocaine, and heroin, with MDMA placing fifth. Treatment admissions data in Hawaii are based on self-reported primary drug information. During this period, primary admissions for **cocaine** use stopped their multiyear decline and rose sharply. Honolulu Police data duplicated the treatment findings, with increases, after a multi-year decline in arrests for cocaine-related offenses. Cocaine remained as the third most frequently analyzed drug by NFLIS laboratories. **Heroin** admissions for treatment again dropped (continuing the 3-year decline reported in June 2009), this time to a near-record low in terms of the time period for which data are available. Police arrests for heroin use decreased as well and paralleled the previous statement in terms of their magnitude, when viewed over time. Heroin has been minimal in the drug items identified by NFLIS. Admissions for treatment with **marijuana** as the primary drug also increased during this period, with no apparent explanation. Marijuana/cannabis, tetrahydrocannabinol (THC), a metabolite of cannabis, or similar products comprised the second most identified drug category analyzed by NFLIS laboratories. While **MDMA** had been included in the “other drug” category in the NFLIS, it now has a regular place in the top five substances identified through the NFLIS. At the meeting of the Honolulu CEWG, the Community Health Outreach Worker program presented its evaluation to the group. This Syringe Exchange Program (SEP) began in 1989 and has increased its penetration of the Intravenous Drug User population systematically and persistently for 21 years. The State of Hawaii does little analysis

of its data on clients in treatment. Univariate statistics are available, but even bivariate data showing profiles of users of specific drugs are not routinely generated, and accessing those data by people who are not affiliated with the Alcohol and Drug Abuse Division is not permitted. No analysis of polydrug use is conducted, nor of recidivists in the treatment system. Although 6-month post-treatment data are collected, differential analyses of those succeeding in treatment compared with those that do not succeed are also not completed. **HIV/AIDS Update:** While one-third of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) cases on the mainland were related to injection drug users (IDUs), in Hawaii that rate is only 17.6 percent. Because the program assigns identification numbers to its clients, longitudinal data have been collected over the years while protecting the identity of the client base. Clients of the SEP are aging, with an average age of 44.4. On average, clients have been injecting for 23 years. Two-thirds of the clients were male, and 56 percent were Caucasian. Heroin was the most commonly injected drug, with 82 percent of clients using heroin. Narcotics other than heroin (primarily pharmaceutical analgesics) were injected by 48 percent of clients, an increase of 14 percent over the previous year. The IDUs using the SEP injected an average of 5.5 days per week and 2.8 times per day. In 1999, 6 percent of clients injected amphetamines; compared with 39 percent in 2002 and 30 percent in 2007. More data from this source will be included in future CEWG reports.

Data Sources: *Data for this period were obtained from the following sources: Hawaii High Intensity Drug Trafficking Area reports; Honolulu Police Department Narcotics and Vice Data sets; Hawaii Office Drug Enforcement Administration Reports; State of Hawaii Office of Narcotic Control; Office of the U.S. Attorney; State of Hawaii, Department of Health, Alcohol and Drug Abuse Division and the Infectious Disease Branch, STD/AIDS Statistics Division; Attorney General's Office; Crime Data Statistics Office; City and County of Honolulu, Office of the Medical Examiner; State of*

Hawaii Department of Business, Economic Development, and Tourism; and Hawaii Drug Policy Forum Reports. Data were also collected from NFLIS; private drug treatment facilities; Department of Psychiatry, University of Hawaii; Queens Hospital; and the Hawaii Health Information Corporation. All data pertain to adults.

Drug Abuse Patterns and Trends in Los Angeles County—Update: January 2010

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Overview of Findings: This report updates data on drug abuse indicators for the Los Angeles County CEWG area since the last reporting period. Overall numbers of treatment admissions in January–June 2009 were about 9 percent lower than those of the corresponding period in 2008 (25,346 and 27,944, respectively). Four primary substances each accounted for approximately one in five admissions: marijuana (23 percent), alcohol (22 percent), methamphetamine (19 percent), and heroin (18 percent). Methamphetamine admissions were stable from calendar year (CY) 2008 levels. Marijuana (38 percent), cocaine (28 percent), and methamphetamine (16 percent) accounted for a majority of Los Angeles-based illicit drug items seized and identified by the National Forensic Laboratory System (NFLIS) for January–June 2009; results indicated a continuing trend of an increasing percentage for marijuana and decrease for cocaine. While remaining very small percentages of NFLIS items, increases over 2008 levels were also seen for items identified as hydrocodone and oxycodone. Reports of opiates/opioids (other than heroin/morphine) also increased among coroner toxicology cases. Wholesale prices for

methamphetamine dropped substantially from 2008 to mid-2009, and some decrease was also seen for cocaine from 2008 to 2009, but these changes were not reflected in street price changes.

Updated Drug Abuse Patterns and Emerging Trends: For January–June 2009, the percentage of alcohol and other drug (AOD) primary treatment admissions for **methamphetamine** were relatively stable over 2008 levels. Hispanics (56 percent) and females (45 percent) continued to represent higher proportions of methamphetamine admissions than they did of admissions for other major substances. Similar to 2008, approximately one in six of NFLIS-reported items identified in forensic laboratories contained methamphetamine, ranking it third among types of substances found (after cocaine and marijuana/cannabis). Mid-2009 wholesale prices for methamphetamine dropped by nearly 25 percent over 2008 levels, and an increase in laboratory seizures also occurred (76 projected for 2009, compared with 46 in 2008). **Cocaine** accounted for 14 percent of Los Angeles County AOD treatment admissions in the first half of 2009, with a continuing majority (58 percent) of African-Americans. Of January–June 2009 NFLIS items, 28 percent contained cocaine, a decrease from 2008 (when cocaine accounted for 33.4 percent of all items). Cocaine was present in 19 percent of coroner toxicology cases. The wholesale price of cocaine decreased in the first half of 2009, from 2008. Treatment admissions for **MDMA** (3,4-methylenedioxymethamphetamine) remained at a very low level (0.2 percent) and remained at a ranking of fifth among drugs identified by NFLIS for Los Angeles County (2.8 percent of items). **Benzodiazepines**, tranquilizers, and sedatives together accounted for a very small percentage (0.5 percent) of total primary treatment admissions. These types of drugs were present in 17 percent of coroner toxicology cases. The category of “other” amphetamines and stimulants, which includes several **prescription drugs**, such as Adderall® and Ritalin®, accounted for 1.5 percent of treatment admissions. In January–June 2009, 18 percent of primary treatment admissions

were for **heroin**, continuing a relatively consistent level since 2005. Heroin was identified in 5 percent of NFLIS items. Heroin/morphine was present in 20 percent of coroner toxicology cases in 2009. About 2 percent of treatment admissions were for **other opioids/narcotics excluding heroin**, stable from 2008 levels. Hydrocodone, oxycodone, and codeine together accounted for 2.4 percent of NFLIS items, a slight increase over 2008 levels (1.6 percent). Most recent data (2008) on retail sales of hydrocodone and oxycodone showed an increase over the previous year. Los Angeles County Coroner toxicology cases showed that other opioids/narcotics were present in 31 percent of cases in 2009. **Marijuana** was reported as the primary drug for 23 percent of Los Angeles County treatment admissions, an increase over 2008 levels (19 percent). More than one-half (54 percent) of marijuana admissions were for adolescents younger than 18. Marijuana/cannabis was identified in 38 percent of NFLIS items, an increase over 2008 levels (34.5 percent). THC (tetrahydrocannabinol), a metabolite of cannabis, was identified in 19 percent of coroner toxicology cases. **Emerging Patterns:** Previously seen decreases in treatment admissions for methamphetamine appeared to be stabilizing, with concern over 2009 decreases in wholesale prices and increases in laboratory seizures. A continuing increasing trend was apparent in marijuana indicators.

Data Sources: *Treatment data were provided by Los Angeles County Department of Public Health, Alcohol and Drug Program Administration (tables produced by California Department of Alcohol and Drug Programs) from CalOMS (California Outcome Monitoring System). CalOMS is a statewide client-based data collection and outcomes measurement system for AOD prevention and treatment services. Submission of admission/discharge information for all clients is required of all counties and their subcontracted AOD providers, all direct contract providers receiving public AOD funding, and all private-pay licensed narcotic treatment providers. Data for this report include admissions in Los Angeles County for*

*January–June 2009. Note that CalOMS was implemented in early 2006 (replacing the earlier CADDs system). Therefore data reported for periods prior to July 2006 may not be exactly comparable to more recent periods. **Forensic laboratory data** were provided by NFLIS, Drug Enforcement Administration, for January–June 2009. **Drug availability, price, and seizure data** were derived from reports from the Los Angeles County Regional Criminal Information Clearinghouse (LA CLEAR) (provided by R. Lovio). The prices included in this report reflect the best estimates of the analysts in the Research and Analysis Unit at LA CLEAR, as available for the Third Quarter Report 2008, based primarily on field reports, interviews with law enforcement agencies throughout the Los Angeles High Intensity Drug Trafficking Area, and post-seizure analysis. **Mortality data** for January–October 2009 were from the Los Angeles County Department of the Coroner (provided by O. Brown) and indicate positive drug results from toxicology cases (not necessarily specific causes of death). **Retail drug sales data** were from the Automation of Reports and Consolidated Orders System (provided by J. Howard) for dosage units in 2008.*

Drug Abuse Patterns and Trends in Maine—Update: January 2010

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Overview of Findings: This report updates four important drug abuse indicators in Maine: arrests and drug seizures through calendar year (CY) 2009 and deaths and treatment admissions through the first half of 2009. Heroin indicators were moderately high but mixed in directionality. Primary heroin treatment admissions, at 16 percent, had declined slightly from the second half of

2008 to the first half of June 2009. Deaths (11 percent) had also declined another 1 percent, continuing a multiyear downward trend since a peak at 24 percent in 2006. Heroin arrests remained stable at 6 percent, but items seized and identified as heroin continued a 3-year increase to 15 percent of total items identified. Cocaine abuse had been growing in Maine through 2007 but began to decline in 2008; that decline continued across all indicators in the 2009 reporting period. Nevertheless, cocaine was still a very substantial component of Maine's law enforcement picture, involving 26 percent of arrests and 43 percent of seizures. A decreasing number of cocaine-induced deaths (at 4 percent of all deaths) and admissions (at 8 percent of total admissions, excluding alcohol) during the first 6 months of 2009 suggested a reduction since 2008. Marijuana indicators continued to be moderately high, with arrests up from 16 percent in 2008 to 23 percent in 2009, after fluctuating around the 20 percent mark from 2006 to 2007. Although the proportion of primary admissions for marijuana increased slightly, from 18 percent in 2008 to 19 percent through the first half of 2009, there had been an overall decline from 2003 to 2008. Seizures, which continued a similar gradual decline from 2003 to 2008, leveled off at 8 percent in 2008 and 7 percent in 2009. Abuse of prescription opiates and opioids, predominantly narcotic analgesics (methadone and oxycodone), continued at relatively high levels. These drugs were frequently used in combination with each other, with benzodiazepines, and/or with alcohol. Arrests for pharmaceutical narcotics have increased since 2007 (when they accounted for 21 percent of all arrests), and they represented 37 percent in the current reporting period. Primary treatment admissions for prescription narcotics continued their multiyear increase, and they constituted more than one-half (56 percent) of all admissions excluding alcohol. However, the number of deaths due to methadone decreased in the first half of 2009 to 29 percent, from 34 percent in 2008. Deaths attributed to benzodiazepines rose to 35 percent during the first 6 months of 2009, compared with 24 percent in 2008. Similarly, although only 88 admissions cited

a primary problem with benzodiazepines, 670 additional admissions noted benzodiazepines as a secondary or tertiary problem, about one-half of which were secondary or tertiary to prescription opiates. Methamphetamine abuse indicators were mixed, and the numbers continued to be very small. The majority (65 percent) of 26 methamphetamine samples were tablets, 94 percent of which also contained caffeine; a minority (12 percent) of the tablets contained MDMA (3,4-methylenedioxymethamphetamine). The 2009 indicators for MDMA increased but remained very low in number.

Updated Drug Trends and Emerging Patterns:

Heroin abuse remained a serious problem in Maine, but most indicators were stable or decreasing in the 2009 reporting period. Heroin/morphine caused 12 percent of drug-induced deaths in 2008 and 11 percent in 2009, continuing downward from a peak of 24 percent in 2005. Six percent of both 2008 and 2009 arrests were for heroin, down slightly from 7 percent in 2007. Drugs seized and identified as heroin rose slightly between 2007 and 2008, from 7 to 8 percent, but they increased more sharply in 2009, up to 15 percent. Primary heroin/morphine treatment admissions for the first half of 2009 were 16 percent of total admissions excluding alcohol, continuing a slightly fluctuating decline since the peak of 22 percent in the second half of 2005. **Cocaine** and prescription narcotics remained the two leading types of substance abuse in Maine, excluding alcohol and tobacco. Nevertheless, all cocaine indicators were decreasing during 2009. Cocaine/crack arrests have dominated the illicit drug activity of the Maine Drug Enforcement Agency in recent years, but the proportion of arrests decreased substantially to 26 percent of arrests in 2009, down from a peak of 45 percent in 2007. Both crack and powder cocaine arrests decreased. Cocaine/crack also constituted the largest single category of samples tested in Maine's forensic laboratory, rising from 36 percent in 2003 to 50 percent in 2007; however, it decreased to 43 percent in 2009. Cocaine-induced deaths rose sharply, from 4 percent in 2002 to a peak of 19 percent in 2006, but they declined to 7 percent in

2008 and 4 percent in the first half of 2009. Primary treatment admissions for crack and cocaine combined had been at a 14-percent plateau from the second half of 2005 through the first half of 2007, but they declined to 8 percent during the first half of 2009 (composed of 3 percent for crack and 5 percent for powder cocaine). Of the samples seized and identified as cocaine in CY 2009, 38 percent tested positive for levamisole, sharply up from 2 percent in 2006. Eleven percent of the 2009 samples tested contained diltiazem. **Marijuana** indicators remained moderately high but were mixed in direction. The proportion of arrests that were marijuana related had generally declined to 16 percent in 2008, but such arrests rose to 23 percent in the 2009 reporting period. Drugs seized and identified as marijuana declined, from 15 percent of laboratory samples in 2003, to 8 percent in 2008, and 7 percent in 2009. The proportion of primary marijuana admissions had been declining over the last several years, although there was a 1-percentage-point increase to 19 percent in the first half of 2009 (from 18 percent in 2008). As a result of a referendum in November 2009, Maine's medical marijuana law has been expanded to allow dispensaries, which will likely affect law enforcement marijuana statistics. Misuse and abuse of **prescription narcotics** remained high in early 2009 indicators, with mixed trend signals. Pharmaceutical narcotics contributed to 37 percent of arrests (continuing up from 21 percent in 2007 and 29 percent in 2008). Seizures of prescription narcotics fluctuated slightly from a multiyear decline, rising 1 percentage point to 13 percent of forensic laboratory samples during 2009 (from 12 percent in 2008). Pharmaceutical narcotics continued to grow in importance. While treatment admissions for these drugs rose from 54 percent of primary admissions, excluding alcohol, in 2008, to 56 percent of admissions in the first half of 2009, deaths fell slightly, from 72 percent of drug-induced deaths during 2008, to 63 percent (partly due to a slight reduction in methadone deaths, from 56 deaths in 2008, to 23 in the first half of 2009). Buprenorphine caused three deaths in 2008 and one during the first half of 2009. It comprised 2 percent

of law enforcement seizures in 2009. Buprenorphine contributed 46 primary and 39 secondary or tertiary admissions during the first half of 2009. Although 65 percent of buprenorphine admissions cited an oral route of administration, 22 percent cited inhalation. Among pharmaceutical narcotics, methadone and oxycodone continued to dominate deaths, arrests, seizures, and poison center exposure and information calls. Methadone-induced deaths, which peaked in 2004 at 46 percent, and had been declining in the interim, fell to 29 percent in the first half of 2009. Oxycodone deaths constituted 25 percent of drug-induced deaths during that time. **Benzodiazepines** continued to play a substantial role in Maine's drug abuse problem in 2009. Although they constituted only 2 percent of seizures and 2 percent of arrests, they caused a record proportion (35 percent) of drug-induced deaths (up from 24 percent in 2008), usually as co-intoxicants in narcotic deaths. Although benzodiazepines represented only about 1 percent of primary admissions, they were seven or eight times more frequently cited as secondary or tertiary problems than as primary problems, usually with prescription narcotics as primary problems. **Methamphetamine** indicators were mixed, but with very small numbers. They constituted 3 percent of the 2009 arrests, up slightly from 1 percent in 2008. Most of the methamphetamine forensic samples tested (65 percent) were tablets, a similar proportion to 2009; 19 percent were identified as crystal. Nearly all of those (94 percent) contained caffeine, although 12 percent of them also contained MDMA. Other substances found occasionally included ketamine (6 percent), procaine (24 percent), TFMPP (1-(3-trifluoromethylphenyl)piperazine) (12 percent), BZP (1-benzylpiperazine) (6 percent), and diphenhydramine (18 percent). There were no deaths due to methamphetamine in the first half of 2009. Primary methamphetamine admissions remained well under 1 percent in the first half of 2009 as in previous reporting periods. **MDMA** indicators were mixed, but with small numbers. MDMA represented 3 percent of total drugs seized and identified in 2009; drugs seized and identified as MDMA increased from 2 in 2007,

to 14 in 2008, to 26 in 2009. MDMA arrests represented only 1 percent of all arrests, but arrests increased, from 2 in 2007 to 8 in 2009. Primary admissions for MDMA constituted only one-tenth of 1 percent in the first 6 months of 2009; there were only four MDMA treatment admissions during January through June 2009. **Emerging issues** included continuing problems with the high volume of prescription drug abuse. Of particular note was the rising percentage of deaths in which benzodiazepines were mentioned as a cause, constituting more than one-third of the drug-induced deaths.

Data Sources: *Treatment admission data* were provided by the Maine State Office of Substance Abuse; these included all admissions for programs receiving State funding. This report includes admissions data from January to June 2009, excluding shelter and detoxification, and comparisons extend back to 2003. **Forensic laboratory data** were provided by the Maine State Health and Environmental Testing Laboratory, which tests samples seized statewide. Data were provided for CY 2009 and compared with previous years back to 2003. **Arrest data** were provided by the Maine State Drug Enforcement Agency (MDEA), which directs eight multijurisdictional task forces covering the State, generating approximately 60 percent of all Uniform Crime Reports drug-related offenses statewide. Also included in the data are local arrests for which MDEA assisted. Data were provided for CY 2009 and compared with previous years back to 2003, including the "assists." **Mortality data** were provided by the State of Maine Office of Chief Medical Examiner for all completed cases from 2000 through June 2009. That office investigates all drug-related cases statewide. In 2008 they changed to the National Medical Services Laboratory, which does screening and quantification for additional substances. Toxicology testing is routinely done on all suspected drug cases.

Drug Abuse Patterns and Trends in Miami/Dade and Broward Counties, Florida—Update: January 2010

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Overview of Findings: Since peaking in early 2007, cocaine consequences continued to decline in South Florida during the first half of 2009. Heroin indicators stabilized in early 2009, following modest increases over the previous 2 years. Deaths related to the nonmedical use of prescription opioids remained at high levels in the first half of 2009, and they increased across the State and in Miami/Dade County while declining in Broward County. Broward County continued to lead the Nation in the amount of oxycodone directly provided by dispensing practitioners. Adolescent marijuana use was trending upward as perceived risks about it are softening, according to local, Florida, and national school surveys. MDMA (3,4-methylenedioxymethamphetamine) was found in combination with BZP (1-benzylpiperazine) and methamphetamine, as all three drugs have been detected in ecstasy tablets. Medical Examiner (ME) occurrences of two benzodiazepines, alprazolam and diazepam, declined during the first half of 2009, by 37 percent in both Miami/Dade and Broward Counties. However, they increased slightly statewide. Emerging issues included the relationship of declining cocaine indicators to lower purity of the drug coming from South America and increasing reports of contaminants (such as levamisole). Additionally, the expansion phase of an “opiate epidemic” may be underway as nonmedical use of prescription opioids among those dying from heroin was observed in ME reports.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine-related deaths

declined 42 percent in Broward County, 24 percent in Miami/Dade County, and 1 percent across the State between the last half of 2008 and the first half of 2009. Cocaine was considered to be the cause of death in one-half of the Broward reports (27 of 55), 15 percent of the Miami/Dade cases (13 of 84), and one-third of cocaine ME reports for all of Florida (236 of 724). Cocaine accounted for 7,498 reports in the Miami/Dade 2008 Drug Abuse Warning Network (DAWN) weighted emergency department (ED) visit estimates and for 5,560 reports in Broward County. The percentage of cocaine unweighted ED reports declined from the first half of 2008 to the first half of 2009 in both counties. Polysubstance use was linked to a majority of cocaine consequences. Levamisole and other adulterants were reported in at least one-half of cocaine toxicology reports. Deaths in which **heroin** was detected increased 22 percent statewide, but they declined in the two Southeast Florida counties during the first half of 2009, compared with the previous 6 months. At least one or more prescription opioid was also detected in 38 percent of the heroin deaths in Miami/Dade and Broward Counties during 2008, indicating concurrent heroin and opioid use. Heroin consequences were more prevalent in Miami/Dade than in Broward. Broward County and most of the State had higher numbers and per capita rates of nonmedical **prescription opioid** consequences than Miami/Dade County. Yet, opioid-related deaths rose slightly in Miami/Dade during the first half of 2009, while declining in Broward. There were 81 occurrences of an opioid identified among deceased persons in Miami/Dade during the first half of 2009 and 159 such reports in Broward. The percentage of unweighted ED reports for nonmedical opioid misuse increased from the first half of 2008 to the first half of 2009 in Broward County and remained stable in Miami/Dade. One-half of the top 50 dispensing practitioners of oxycodone in the United States were located in Broward County during the 6 months from October 2008 to March 2009. These physicians dispensed 5.25 million dose units of oxycodone in the same period. Oxycodone is the most frequently cited prescription opioid observed

in most abuse indicators. Consequences of **methamphetamine** abuse remained low, representing less than 1 percent of unweighted ED reports in both counties. However, those reports doubled in Miami/Dade County, from 11 to 20, and from 8 to 17 in Broward, between the second half of 2008 and the first half of 2009. Statewide, methamphetamine-related deaths decreased 29 percent, from 55 in the last half of 2008 to 39 in the first half of 2009. Methamphetamine and BZP continued to be detected in **MDMA/ecstasy** tablets. Statewide, MDMA-related deaths decreased 45 percent, from 22 in the last half of 2008 to 12 in the first half of 2009. South Florida trends were stable for both methylated amphetamines. Indicators of **marijuana** consequences remained stable and high; marijuana ranked first in primary treatment admissions (including alcohol). Marijuana accounted for 3,378 ED visits in the Miami/Dade 2008 DAWN estimates and 2,928 estimated ED visits in Broward. The 2009 Florida Youth Substance Abuse Survey reported increases in any past-30-day use of marijuana for 8th and 12th graders statewide, reversing what had been a declining trend over the past decade. These State findings paralleled the national results of the 2009 Monitoring the Future Survey that revealed use has increased as beliefs about the perceived harmfulness of using marijuana regularly has declined about 5 percentage points since 2000 for 8th, 10th, and 12th grade levels. Alprazolam continued as the most frequently cited **benzodiazepine** observed in most abuse indicators, and clonazepam replaced diazepam for second place. There were 57 occurrences of either alprazolam or diazepam identified among deceased persons in Miami/Dade County during the first half of 2009 and 158 such reports in Broward—decreases of 37 percent over the numbers for the second half of 2008 in both counties. The percentage of unweighted ED reports for non-medical benzodiazepine misuse increased slightly from the first half of 2008 to first half of 2009 in Broward County and remained stable in Miami/Dade County. **Emerging Patterns:** The continued decline of cocaine consequences locally and nationally may be related to declining purity of the

drug as trafficked from Colombia. The increasing number of cocaine samples adulterated with levamisole and other substances before reaching the United States illustrates declining cocaine purity. Toxicology reports of nonmedical opioid use among heroin decedents suggested the prescription drug misuse problem may be escalating as an “opiate epidemic.” Most drug deaths are preventable, with multiple missed intervention opportunities.

Data Sources: *Drug-related death data came from the Florida Medical Examiners Commission 2009 Interim Report on Drugs Identified In Deceased Persons by Florida Medical Examiners, covering the first half of 2009 from the Florida Department of Law Enforcement. Unweighted ED DAWN Live! data from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, are reported for the period January–June 2009 separately for the Miami/Dade and Ft. Lauderdale Divisions. Weighted DAWN ED visit estimates are presented for 2008. Treatment data from the Florida Department of Children and Families for all publicly funded adult and youth treatment programs in Miami/Dade and Broward Counties included unduplicated primary admissions for all treatment modalities for January–June 2009. Forensic laboratory data were provided by the National Forensic Laboratory Information System, Drug Enforcement Administration (DEA), for January to June 2009. Information on prescription opioids was provided by the Interim Report of the Broward County Grand Jury on the Proliferation of Pain Clinics in South Florida, November 2009. Prescription distribution data were provided by the Automation of Reports and Consolidated Orders System, DEA, for October 2008–March 2009. School survey data were provided by Monitoring the Future Survey 2009, National Institute on Drug Abuse and University of Michigan, and by the Florida Youth Substance Abuse Survey 2009, Florida Department of Children and Families.*

Drug Abuse Patterns and Trends in Minneapolis/St. Paul—Update: January 2010

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Overview of Findings: This report is produced twice annually for participation in the Community Epidemiology Work Group of the National Institute on Drug Abuse, an epidemiological surveillance network of researchers from 21 U.S. metropolitan areas, and is also available for download at http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_147922.pdf. The Minneapolis/St. Paul (“Twin Cities”) metropolitan area includes Minnesota’s largest city, Minneapolis (Hennepin County), the capital city of St. Paul (Ramsey County), and the surrounding counties of Anoka, Dakota, and Washington. Recent estimates of the population of each county are as follows: Anoka, 313,197; Dakota, 375,462; Hennepin, 1,239,837; Ramsey, 515,274; and Washington, 213,395. The total population of these counties is 2,557,165, or roughly one-half of the Minnesota State population. In the five-county metropolitan area, 84 percent of the population is White. African-Americans constitute the largest minority group in Hennepin County, while Asians are the largest minority group in Ramsey, Anoka, Dakota, and Washington Counties.

Updated Drug Abuse Trends and Emerging Patterns: The most notable drug abuse shift in the Twin Cities metropolitan area was the marked decline in **cocaine**-related treatment admissions in the first half of 2009. Cocaine was the primary substance problem for 6.4 percent of total treatment admissions in the first half of 2009, compared with 9.9 percent in the first half of 2008, and 11.6 percent in 2007. Most cocaine

admissions were for crack cocaine, and most clients (70 percent) were age 35 or older. Almost one-half (49 percent) were African-American. Treatment admissions for both **heroin** and other opiates have steadily increased since the turn of the century. However, in this reporting period heroin-related admissions were generally stable, accounting for 6.5 percent of total treatment admissions in the first half of 2009, compared with 6.7 percent in the first half of 2008. Admissions involving **other opiates** continued an upward trend, accounting for 7.5 percent of total admissions in the first half of 2009, compared with 6.2 percent in the first half of 2008. For the most part, these admissions involved the nonmedical use of prescription pain medications. Of those clients admitted to treatment for other opiates, almost one-half (46 percent) were female, and oral was the primary route of administration (74 percent). Treatment admissions for **methamphetamine** increased slightly in 2009, following a decline that began in 2006. They accounted for 5.9 percent of treatment admissions in the first half of 2009, compared with 5.5 percent in the first half of 2008, and 12 percent in 2005 (the highest year). Seizures of methamphetamine by law enforcement surpassed those of cocaine in the first half of 2009. Cocaine accounted for 20.2 percent of items seized and identified by National Forensic Laboratory Information System (NFLIS), and methamphetamine accounted for 27.5 percent in the first half of 2009. Hospital emergency department (ED) estimated visit data showed a 42-percent decline in methamphetamine-involved visits from 2004 to 2008 (from 1,741 in 2004 to 1,001 in 2008). One-third of items seized were identified as **marijuana/cannabis**. Treatment admissions with marijuana as the primary substance problem accounted for 18.7 percent of total treatment admissions in the first half of 2009, compared with 16.9 percent of total treatment admissions in the first half of 2008. Most clients (66 percent) admitted to treatment for marijuana dependence were under age 26. Many (39.8 percent) had no prior treatment experience. The average age of first marijuana use was 14.3 years, the youngest age within any drug category. Addiction treatment programs continued to treat

more clients for alcoholism than for any other drug disorder. In the first half of 2009, 53.1 percent of treatment admissions reported **alcohol** as the primary substance problem. Most (58 percent) were age 35 or older. The average age of first alcohol use was 15.5. According to the 2009 College Student Health Survey of 5,692 students from nine Minnesota colleges and universities, 64.9 percent reported using alcohol in the past 30 days. High-risk drinking, defined as five or more drinks at one sitting in the past 2 weeks, was reported by 32.8 percent of students (41.3 percent of male and 28.1 percent of female students). Students who reported high-risk drinking were also significantly more likely to report negative consequences related to their drinking, including Driving While Intoxicated arrests.

Data Sources: *Treatment data* came from addiction treatment programs (residential, outpatient) in the five-county Twin Cities metropolitan area, as reported on the Drug and Alcohol Abuse Normative Evaluation System of the Minnesota Department of Human Services (through June 2009). *Hospital ED data* are weighted visit estimates from the Drug Abuse Warning Network, administered by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration. *Crime laboratory data* came from NFLIS, Drug Enforcement Administration. *College student alcohol use data* were from the 2009 College Student Health Survey, conducted by Boynton Health Service, University of Minnesota; N=5,692 students, randomly selected from 9 Minnesota colleges and universities.

Drug Abuse Patterns and Trends in New York City—Update: January 2010

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Overview of Findings: Cocaine indicators were mixed for this reporting period, with several decreasing, but cocaine remained a major problem in New York City. New York City is considered the most significant heroin market and distribution center in the country. While New York City heroin indicators were mixed, several indicators pointed to a dramatic increase in heroin and other opiate use and consequences in the suburban area surrounding New York City. Marijuana indicators were at a high level and continued to increase. Marijuana continued to be considered high quality and widely available. Treatment admissions for marijuana increased to the highest number ever. Although prescription drug use remained low compared with the use of other substances, many kinds of prescription drugs were available on the street. Methamphetamine indicators in New York City remained low, and there was little availability or selling activity. Most indicators for MDMA (3,4-methylenedioxymethamphetamine) and other club drugs remained low.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine indicators were mixed, but several showed signs of decreasing. Primary cocaine treatment admissions decreased, but more clients in treatment had a primary, secondary, or tertiary problem with cocaine than with any other drug. Drug Abuse Warning Network (DAWN) weighted data showed a significant increase in estimated cocaine-involved visits between 2004 and 2008, but a significant decrease between 2007 and 2008. There were more DAWN Live! unweighted ED reports for cocaine, as well as more National Forensic Laboratory Information System (NFLIS) items seized and identified as cocaine, than for any other drug. The most recent death data showed a decrease in cocaine deaths between 2006 and 2007. Street reports were that cocaine was highly available, but that crack quality was lower than in previous reporting periods. **Heroin** remained a major problem in New York City. More than one-quarter of all primary treatment admissions were for heroin, although the number of treatment admissions declined slightly

to the lowest number since 1999. Among primary heroin treatment admissions, the percentage of injectors rose slightly to 40 percent, the first semi-annual period it has reached 40 percent since 1997. There were no significant changes for heroin in the DAWN weighted visit data for 2004 to 2008. Eleven percent of NFLIS items seized and identified were heroin. Heroin deaths increased in the New York/New Jersey/Pennsylvania region from 2006 to 2007. Several indicators pointed to a dramatic increase in heroin and other opiate use and consequences in the suburban area surrounding New York City (including unweighted DAWN heroin-involved visits, number of admissions to non-crisis services, and heroin death data). **Marijuana** indicators remained at a high level. Marijuana primary treatment admissions increased to the highest number ever and represented almost one-quarter of all treatment admissions. Almost one-third of NFLIS items seized and identified were marijuana. There were more DAWN *Live!* reports for marijuana than for heroin; only cocaine and alcohol had more reports than marijuana. DAWN weighted ED visit estimates showed that marijuana-involved visits increased significantly between 2004 and 2008. Marijuana continued to be of good quality and widely available. Marijuana in a blunt cigar often served as the base to which other drugs are added. **Methamphetamine** indicators remained low. Treatment admissions, DAWN *Live!* reports and weighted ED visits, and NFLIS items involving the drug were all at very low levels. According to the New York State Office of Alcoholism and Substance Abuse Services (OASAS) Street Studies Unit (SSU), there was little methamphetamine availability or selling activity. **MDMA** indicators remained low. NFLIS data on drugs seized and identified may indicate an increase in MDMA, as it ranked 6th among all drugs in the first half of 2009, compared with 11th in 2008. **Prescription drug** indicators were mixed. Although most indicators remained low, there continued to be street study reports that pills were gaining in popularity. Treatment admissions for other opiates have increased in both New York City and other areas of New York State over previous reporting

periods. DAWN weighted ED visit data showed significant increases in prescription drug-involved visits between 2004 and 2008 for opiates/opioids as a category (specifically methadone, oxycodone, and hydrocodone) and for benzodiazepines as a category (specifically alprazolam). Although prescription drugs represented only a small number of NFLIS items analyzed, the specific drugs that accounted for more than 100 items each were alprazolam, oxycodone, methadone, hydrocodone, clonazepam, and buprenorphine. **Other drugs:** Weighted DAWN estimates increased significantly for **LSD** (lysergic acid diethylamide)-involved ED visits for 2004 to 2008 and for 2006 to 2008. DAWN **PCP** (phencyclidine)-involved ED visits also increased for 2004 to 2008, and for 2006 to 2008. **BZP** (1-benzylpiperazine) moved from 32nd on the list of NFLIS items seized and identified to 14th—from 4 items analyzed in the first half of 2008 to 101 items in the first half of 2009. **HIV/AIDS Update:** Of the 105,633 New Yorkers living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) as of December 31, 2008, men having sex with men and injection drug use history continued to be the two major transmission risk factors. Men comprised an increasing proportion of new HIV diagnoses. Minorities continued to be disproportionately affected by HIV—more than 80 percent of new HIV/AIDS diagnoses in 2008 were among Blacks and Hispanics. People living with HIV/AIDS (PLWHA) were aging. The proportion of PLWHA age 50 and older rose, from 25 percent in 2003 to 37 percent in 2008.

Data Sources: *ED data were derived for the first 6 months of 2009 from the DAWN Live! restricted-access online query system administered by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). Eligible hospitals in the New York Five Boroughs Division totaled 52; hospitals in the DAWN sample numbered 40, with the number of EDs in the sample totaling 61. (Some hospitals have more than one ED.) During this 6-month period, between 36 and 39 EDs reported data*

each month. The completeness of data reported by participating EDs varied by month. Exhibits in this report reflect cases that were received by DAWN as of December 10, 2009. All DAWN cases are reviewed for quality control. Based on this review, cases may be corrected or deleted. Therefore, the data presented are subject to change. Data derived from DAWN Live! represent drug reports in drug-related ED visits. Drug reports exceed the number of ED visits, since a patient may report use of multiple drugs (up to six drugs and alcohol). The DAWN Live! data are unweighted and are not estimates for the reporting area. These data cannot be compared with DAWN data from 2002 and before, nor can preliminary data be used for comparison with future data. Only weighted DAWN data released by SAMHSA can be used for trend analysis. DAWN Live! data for the New York Suburban division are based on the counties of Nassau, Putnam, Rockland, Suffolk, and Westchester New York. Eligible hospitals total 41; hospitals in the DAWN sample number 32, with the number of EDs totaling 33. During the study period, between two and three EDs reported data each month. Data in this report for the Suburban division reflect cases that were received by DAWN as of July 26, 2009. ED data for calendar years 2004–2008 were derived from the DAWN, OAS, SAMHSA. The weighted ED visit data are based on a representative sample of hospitals in the five boroughs of New York City. A full description of the DAWN system can be found at <http://dawninfo.samhsa.gov>. **Treatment admissions data** were provided by OASAS for 1991 through the first half of 2009 and included both State-funded and nonfunded admissions. Demographic data were for the first half of 2009. **Drug abuse-related death data** came from the DAWN mortality system. Data from 2006 to 2007 covered New York, northern New Jersey, and Long Island. For 2006, the following 10 counties participated: the five boroughs of New York City; Putnam, Rockland, and Suffolk Counties in New York; and Morris and Union Counties in New Jersey. In 2007, these 10 counties plus Hunterdon County in New Jersey participated. **Forensic laboratory testing data** for New York City were provided by the Drug

Enforcement Agency's (DEA) NFLIS for the first half of 2009. The data include New York Police Department laboratory data for the five boroughs of New York City, as well as data from New York State and DEA laboratories. **Drug price, purity, and trafficking data** were provided by OASAS SSU reports. **AIDS and HIV data** were provided by the New York City Department of Health and Mental Hygiene, HIV Epidemiology and Field Services Program, including the HIV Epidemiology and Field Services Semiannual Report, Vol. 4, No. 2 covering January 1, 2008–December 31, 2008.

Drug Abuse Patterns and Trends in Philadelphia—Update: January 2010

Samuel J. Cutler

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Overview of Findings: This report updates data on drug abuse indicators for Philadelphia since the last CEWG report for this area in June 2009. Much of the data is for the first 6 months of 2009, compared with prior periods from their respective data sources.

Updated Drug Abuse Trends and Emerging Patterns: The drugs/drug groups below are commented on in descending order of their impact. High levels of the use of **marijuana** continued. Marijuana ranked first in treatment admissions (26.2 percent), first in National Forensic Laboratory Information System (NFLIS) laboratory testing data (35.4 percent of samples seized and identified), and first in the Philadelphia Adult Probation and Parole Department (APPD) (57.7 percent of all urine drug screens). Treatment admissions data identified marijuana as the most common secondary drug of abuse—used in combination

with cocaine, benzodiazepines, and PCP (phencyclidine). Treatment admission trends have been fairly stable since 2001 with respect to gender, ranging from 77 to 82 percent male. The percentage of African-Americans entering treatment increased from 70 to 77 percent from 2003 to mid-2009, while proportions of Asians/others declined during that time to very low levels. The proportions by age group for treatment admissions for marijuana have remained stable from early 2005 through mid-2009. Clients under age 21 constituted from 9 to 9.9 percent; age 21–30, from 44 to 48.6 percent; age 31–40, from 23 to 27 percent; and age 41 and over, from 17.7 to 19 percent. **Alcohol** was the second most frequently mentioned drug in treatment admissions data, comprising 23.5 percent of all admissions in the first half of 2009. The treatment admissions trends for alcohol from 2001 through mid-2009 showed increases in the proportions of African-Americans (from 61 to 72 percent), clients age 21–30 (from 18 to 30.5 percent), and males (from 59 to 71.8 percent), with concomitant declines in Whites, clients age 31 to 40, and females. Deaths with the presence of alcohol in combination numbered 323 in 2005, declined to 223 in 2008, and were projected to total 248 in 2009. Alcohol was detected in 23.5 percent of drug-positive decedents in the first half of 2009. Clients in treatment most commonly reported alcohol use in combination with cocaine, and mortality data showed alcohol most frequently detected along with cocaine, benzodiazepines, and/or prescription opioids. Alcohol remained seventh in the APPD study, with 4.6 percent of the samples testing positive. Indicator data for **cocaine** abuse have been declining in the areas of treatment, mortality, NFLIS, and APPD urinalysis. Cocaine treatment admissions comprised 29.3 percent in 2002 but declined to 21.6 percent by mid-2009. There has been a notable shift in cocaine treatment admissions by gender, with females comprising 41 percent in 2001 but only 28.2 percent in mid-2009. Additionally, the treatment-seeking population for cocaine has shifted to an older cohort during the past 4 years, with more than 48 percent of treatment admissions being older than 40 in the first half of 2009. Crack smoking continued as the

dominant form of cocaine use; 81.8 percent of clients entering treatment in the first half of 2009 identified smoking as their preferred route of administration. Detections of cocaine in decedents declined by 9.5 percent between 2008 and the first half of 2009. NFLIS samples seized and identified as cocaine declined from 40.8 percent in 2007, and 37.4 percent in 2008, to 34.7 percent in the first half of 2009. Among probationers and parolees who were tested for the first time (APPD data), cocaine-positive screens declined from 41.5 percent in 2001 to 27.1 percent by mid-2009. Mortality data from the first half of 2009 revealed that cocaine was most commonly used in combination with prescription opioids, benzodiazepines, and/or alcohol. The street-level purity of **heroin** declined from 2000 (73 percent) to 2004 (52 percent), and has been either 55 or 56 percent from 2005 through 2008. The price per milligram pure has fluctuated from \$0.71 in 2004, to \$0.58 in 2005, \$0.63 in 2006, \$0.71 in 2007, and \$0.60 in 2008; however, the standard bag price remained \$10 and contained one “hit.” In the first half of 2009, indicators for heroin declined in the treatment and mortality measures. Heroin continued to rank fourth in treatment admissions, at 14.5 percent (declining from more than 17 percent in 2008), third in deaths with the presence of drugs at 20.3 percent (having ranked second in 2008), and third in NFLIS data (14.0 percent); it moved from fifth to fourth in the APPD data (within the category “total opioids,” at 14.5 percent). At the beginning of the period of declining heroin purity in 2001, Whites comprised 54 percent of treatment admissions; this proportion had increased to over 68 percent by 2006. In mid-2009, Whites comprised 65.5 percent of treatment admissions for heroin. Proportions of African-Americans declined from 42 percent in 2001, to 22 percent in 2006, and rebounded to 28 percent by mid-2009. As the purity levels bottomed out, the 21–30 age group entered treatment in increasing proportions (from 22 percent in 2001 to 42 percent in 2005), and as the purity leveled off in 2006, so did this population entering treatment, with 42.3 percent in the first half of 2009. Deaths with the presence of heroin closely matched the purity trends from 2001

through 2008, with the exception of the period of the fentanyl outbreak from spring 2006 to spring 2007; based on mid-year 2009 data, a small decline in deaths with the presence of heroin was projected. People who died with heroin in their systems were most frequently positive for prescription opioids and/or benzodiazepines. In the first half of 2009, 82.1 percent of females and 81.8 percent of males reported injection as their preferred route of administration at admission to treatment. Within the **other opioids** category, use was characterized as at medium levels with mixed indicator results, depending on the drug. Codeine and oxycodone remained low in treatment admissions, but relatively high in the Philadelphia Medical Examiner's (ME's) toxicology reports. However, three pharmaceutically produced opioids were in the top 10 drugs in the NFLIS report for the first half of 2009—oxycodone (fourth), hydrocodone (seventh), and codeine (eighth). As mentioned in the section on heroin, there were increases in APPD urinalysis results for "total opioids." **Benzodiazepine** use, while lower than use of marijuana, alcohol, cocaine, or heroin, continued to be common in conjunction with other drugs, according to trend data. Increases over previous reporting periods were noted in treatment admissions. The ME increased its testing protocols for benzodiazepines in July 2008, and it was not yet known if the increases in ME detections since then were due to revised testing or increased use of these drugs. Alprazolam was clearly the most widely used benzodiazepine, ranking fourth in the ME's toxicology reports and fifth in NFLIS data. Alprazolam was most commonly used in combination with heroin, oxycodone, and/or marijuana. **PCP** (phencyclidine) was primarily smoked in combination with marijuana in "blunts." Indicators reflected medium levels of use, compared with other drugs, and indicators were mixed in the first half of 2009. Treatment demographics, dominated by males, African-Americans, and clients in their 20s, were stable, but the number of admissions increased. PCP continued to rank sixth in the numbers of items seized and identified by NFLIS, and APPD results were stable from 2008 to mid-2009. There were

fewer PCP-positive decedents projected for 2009, compared with previous years. Among **antidepressants**, data were only available from the ME's Office. Relatively low levels of use have been detected, and the full year 2009 projection was similar to the 2008 result. Use of **methamphetamine and other amphetamines** remained at very low levels. There were only 4 treatment admissions for methamphetamine and 23 for other amphetamines in the first half of 2009. Mortality data for these drugs were also low, but they reflected a total of 22 detections of methamphetamine, amphetamine, and **MDMA** (3,4-methylenedioxymethamphetamine) among the 16 cases.

Data Sources: *Treatment admissions data were provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services, Behavioral Health Special Initiative, for the uninsured population only. Data on deaths with the presence of drugs were obtained from the City of Philadelphia Department of Public Health, ME's Office. Criminal justice data consist of the random urinalysis program of the APPD, which analyzed samples for the first time testing (only) of individuals on probation or parole. Heroin purity and price data were provided by Drug Enforcement Administration's (DEA) Heroin Domestic Monitor Program for 2008 and earlier periods. Forensic laboratory data came from NFLIS, DEA, for the first half of 2009. Note: hospital emergency department (ED) data were not available because Philadelphia is not associated with the Drug Abuse Warning Network Live! hospital ED data collection system.*

Drug Abuse Patterns and Trends in the Phoenix Area and Arizona—Update: January 2010

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Overview of Findings: This report updates data on drug abuse indicators for the Phoenix area (Maricopa County) since the last reporting period in June 2009. Much of the data covers the first half of 2009. Amphetamine/methamphetamine-related hospital admissions were flat in the first half of 2009. Methamphetamine treatment admissions declined as a percentage of total admissions. Indicators for cocaine problems were down—cocaine-related hospital admissions and primary cocaine treatment admissions declined. Marijuana indicators were mixed. Heroin treatment admissions increased as a percentage of total treatment admissions. Drug Abuse Warning Network (DAWN) estimated emergency department (ED) visits for heroin and opioids (oxycodone, hydrocodone, morphine, and methadone) rose during 2004–2008. Although the primary form of heroin consumed in Arizona was black tar, seizures continued to suggest that Phoenix may serve as a feeder city for white heroin arriving from Mexico. White heroin, however, has not been encountered by street-level distributors based in the Phoenix area, based on Drug Enforcement Administration (DEA) reports.

Updated Drug Abuse Trends and Emerging Patterns: Of all treatment admissions that indicated a primary drug of abuse in the first half of 2009, **methamphetamine** was the illicit drug reported most often (at 23 percent). (**Alcohol** was the most common drug reported, at 36 percent.) The percentage of all treatment admissions with methamphetamine as the primary drug (with alcohol included) decreased slightly in the first half of 2009, from 24.5 percent in 2008. After declining sharply in 2007, amphetamine/methamphetamine-related hospital admissions were flat during 2008 and the first half of 2009. Items seized and identified by the National Forensic Laboratory Information System (NFLIS) as containing methamphetamine decreased in the first half of 2009 (20 percent), compared with the first half of 2008 (23 percent). Seizures of clandestine methamphetamine laboratories fluctuated over the previous 18 months, with no clear trend. **Cocaine** was reported by 6 percent of treatment admissions reporting a

primary drug in the first half of 2009; this percentage (with alcohol included) represented a decrease from 2008 (8.5 percent). After rising steadily during 2005 and 2006, cocaine-related hospital admissions began declining in the first half of 2007; they continued declining through the first half of 2009. Cocaine items seized and identified by NFLIS also decreased in the first half of 2009 (19 percent), compared with the first half of 2008 (20.5 percent). There were approximately 220 estimated ED visits involving **MDMA** (3,4-methylenedioxymethamphetamine) in 2008, the highest number in 4 years (compared with 73 visits in 2005 and 94 in 2007), but still small when compared with methamphetamine-involved ED visits in 2008 ($n=3,002$). The number of items seized and identified by NFLIS as containing MDMA increased in the first half of 2009, compared with the first half of 2008. During the first half of 2009, **marijuana** as a primary drug was reported by 15 percent of the treatment admissions reporting a primary drug, the same percentage reported in the first half of 2008. Estimated ED visits involving marijuana were flat in 2007 and 2008. Items seized and identified as marijuana, and reported by the DEA Tucson District Office, increased from 229,034 pounds in the first half of 2008 to 397,065 pounds in the first half of 2009. Ultralight aircraft were being used to help smuggle marijuana into Arizona from Mexico, according to the DEA. The typical load appeared to be about 300 pounds. **Heroin** was the primary drug of abuse reported by 14 percent of the treatment admissions reporting a primary drug, a slight increase from the 13 percent reporting heroin in the first half of 2008. Heroin-involved estimated ED visits increased significantly from 2004 to 2008, with visits estimated at 2,085, 2,364, and 2,712 in 2006, 2007, and 2008, respectively. The number of heroin/opioid-related hospital admissions with skin abscesses (a problem often arising from needle use) increased from the first half of 2007 through the first half of 2009. Although Arizona has been almost exclusively a black tar heroin area for decades, seizures indicated that Phoenix also may be serving as a feeder city for white heroin arriving from Mexico. The white heroin

was apparently being transported to midwestern and northeastern wholesale distribution markets; to date, white heroin has not been encountered by local wholesale or street-level distributors based in the Phoenix area, according to DEA sources. Estimated ED visits involving **oxycodone** and **morphine** increased in 2008, compared with 2006, and ED visits involving **hydrocodone** increased in 2008, compared with 2006 and 2007. **HIV/AIDS:** New data on human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) related to drug abuse were unavailable to update rates reported at the June 2009 CEWG meeting. **Emerging Patterns Regarding Use:** In 2009, Phoenix Police Department officers dismantled an MDMA drug ring, resulting in the arrest of 10 dealers. Also in 2009, two individuals were arrested for possession of chemicals to manufacture MDMA. Such information, coupled with the increases in MDMA-involved ED visits and NFLIS MDMA items noted above, suggests that the drug may be an emerging problem and should continue to be monitored. **Emerging Patterns Regarding Smuggling:** Heroin and cocaine have been hidden in the soles of the shoes and boots of persons crossing the Arizona–Mexico border. In Nogales (an Arizona–Mexico border city), the number of tunnels for smuggling drugs appeared to have increased during this last reporting period.

Data Sources: *Treatment data for admissions age 18 and older came from the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services. Hospital admissions (inpatient) data came from analyses conducted by the University of Arizona, Department of Family and Community Medicine, using hospital discharge records from the Arizona Hospital Discharge Data System operated by the ADHS. Estimated ED visits came from DAWN, Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Law enforcement data, including clandestine laboratory seizure data, were from the DEA and the National Drug Intelligence Center. Forensic drug analysis data were from NFLIS, DEA.*

Drug Abuse Patterns and Trends in St. Louis, Missouri—Update: January 2010

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Overview of Findings: During the first 6 months of 2009, an increase in heroin indicators in the St. Louis metropolitan area was a major concern. Anecdotal information indicated that heroin use and availability, as well as treatment admissions, may have increased. Many of the indicators for the other major substances of abuse remained relatively stable or were down through the first half of 2009. Alcohol and other drug categories have shown some decrease in treatment admissions, but deaths and arrests appeared more stable. Cocaine indicators decreased in treatment admissions data and death data for St. Louis City and County during two recent 6-month reporting periods (death data were reported for the first half of 2008 and the first half of 2009). Prescription narcotic analgesics were reported to be available in the more rural areas of the St. Louis Metropolitan Statistical Area (MSA). Indicators for both cocaine and opiates will need continued monitoring to determine if there have been changes in these markets or in the user populations. Methamphetamine indicators were stable in the first 6 months of 2009. The poor economy has resulted in reduced State and local budgets, which may have an impact on several indicators of drug use.

Updated Drug Abuse Trends and Emerging Patterns: Alcohol was the primary drug of abuse for clients entering publicly funded treatment programs in Missouri. Treatment admissions increased from 2006 to 2007 and again in 2008. However, the number of primary admissions for alcohol abuse decreased from the first half of

2008 (2,119) to the first half of 2009 (2,061). Alcohol was frequently indicated as a secondary drug of abuse. The 2008 Missouri School Survey showed only a slight increase in 30-day use among 6th and 12th graders from 2006 levels. Alcohol was frequently identified among positive screens among probationers and parolees and those incarcerated. Most **cocaine** indicators decreased from the first half of 2008 to the first half of 2009. Treatment admissions decreased almost one-third, from 1,235 in the first 6 months of 2008 to 825 in the first 6 months of 2009. Cocaine remained the second most identified drug in the National Forensic Laboratory Information System (NFLIS) but represented only 15.1 percent of items in the first half of 2009, versus 22.5 percent of items in calendar year (CY) 2007. Deaths increased in the last 6 months of 2008. While identified as a major drug problem in the St. Louis area, recent concern about heroin abuse has taken attention from cocaine. Law enforcement officials reported a decrease in cocaine availability, which has resulted in an increase in prices and decreases in purity. No change in 30-day cocaine use (2.4 percent) was noted between the 2006 and 2008 Missouri School Surveys. The **heroin** market in the St. Louis region has grown and become more complex over the past few reporting periods. From the first half of 2008 to the first half of 2009, treatment admissions increased by 14.0 percent and rival total admissions for marijuana abuse in the area. Two types of heroin were available—Mexican black tar coming to the region from the Southwest and, more recently, South American (SA) heroin. Increased involvement of Mexican dealers has complicated the market. Heroin Domestic Monitor Program analyses in 2008 reflected this growing, competitive heroin market in the St. Louis area, with decreasing purity in black tar heroin and increasing purity in the SA heroin. South American and Mexican black tar were represented in the samples. Deaths have increased in both the city and county, with most of the surrounding rural counties reporting heroin deaths. Indicators for opiates have increased for both heroin and other opiates. This increase is consistent with reported availability for heroin and reports from rural law

enforcement about increased usage. Heroin represented 10 percent of identified drugs in the first half of 2009 NFLIS data, up from 6.2 percent of identified drugs in CY 2007. The available indicators for **other opiates** increased during this reporting period. Treatment admissions increased 33.1 percent during this period. While the actual number of admissions was relatively low (157), there was still reason for concern, as anecdotal information indicated that abuse of narcotic analgesics has been on the rise in this region. This is especially true in some of the rural areas surrounding the central city where prescription narcotics are prevalent. **Marijuana** treatment admissions decreased 13.3 percent from the first half of 2008 to the first half of 2009. Marijuana/cannabis was the most frequently cited substance identified in the first half of 2008 and the first half of 2009 NFLIS reports for the St. Louis MSA. Also, a slight increase (7.2 versus 7.8 percent) in 30-day marijuana use was noted in the Missouri School Survey from 2006 to 2008. Tetrahydrocannabinol (THC), a metabolite of cannabis, was frequently identified among positive screens among probationers and parolees and those incarcerated. **Methamphetamine** indicators appeared to be mixed. Treatment admissions decreased in the St. Louis region from the first half of 2008 (173) to the first half of 2009 (141), while clandestine methamphetamine laboratory seizures remained stable. While it is believed that the bulk of the available methamphetamine was being imported from Mexico, reports of “ice” from Mexico were not well substantiated. The pseudoephedrine control legislation has led to more creative ways of networking for the local “cooks” to gain access to the chemicals needed to make methamphetamine. Interestingly, the eastern half of the State remained relatively active in clandestine laboratory operations; 184 clandestine laboratories were reported in a rural county (Jefferson) of the MSA as of the last week of 2009. Statewide, 1,453 clandestine laboratories were reported as of the last week of 2009, compared with 1,487 in 2008. There was little change in 30-day methamphetamine use (2.8 versus 2.7 percent) noted in the Missouri School Survey. **Prescription drug** abuse has been

growing, particularly in the rural areas. However, it has been difficult to access data to substantiate this trend, although treatment admissions for benzodiazepines increased by two-thirds from the first half of 2008 (25) to the first half of 2009 (42). In the rural areas near St. Louis, benzodiazepines made up almost 23 percent of positive screens among those tested in facilities and probation and parole offices. There have been multiple reports from key informants about increases in prescription drug use and in the continued use of **MDMA** (3,4-methylenedioxymethamphetamine) in select populations. An increase in 30-day use of MDMA between 2006 (2.2 percent) and 2008 (2.5 percent) was noted in the Missouri School Survey. The National Monitoring of Adolescent Prescription Stimulant Study (NMAPSS) project documented lifetime use of MDMA among those age 16–18 at 11 percent (males) and 13 percent (females). **HIV/AIDS Update:** Data available from the St. Louis City Health Department and the Missouri Department of Health and Senior Services for 2008 indicated that the risk factor of injection drug use does not play a major role in the transmission of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) in the St. Louis area. However, men having sex with men and heterosexual contact in minority populations are more prominent risk factors. The role of alcohol and other drug use among these populations is a key factor. **Emerging Patterns:** Indicators for many substances appeared to be stable or even decreasing. However, the increase in a number of opiate abuse indicators was cause for concern and continued monitoring. A synthesis of all data sources leads to the conclusion that the heroin problem in St. Louis is becoming larger and more complex, with the market becoming more diverse and the drug becoming available to a wider range of users, including those living in rural areas.

Data Sources: Analysis of drug trends for the St. Louis region requires multiple data sources; a number of sources have been used for this report. Missouri Treatment Episode Data Set admissions for the first 6 months of CYs 2008–2009 provided

invaluable indicators for **treatment data**. The Missouri Department of Corrections Probation, Parole and Inmate Toxicology Reports, for CYs 2003–2008, provided a rich source of information about a hard-to-reach population that is closely tied to the end user population and their drug issues in the State (**probationers, parolees, and those incarcerated**). The January–June 2009 NFLIS reports for the St. Louis MSA provided **forensic information** and offered a unique view of drug trends for a variety of substances. The Missouri Department of Health and Senior Services **HIV/AIDS** data FY 2006–2008 and the local St. Louis City Health Department provided measures of HIV, AIDS, and other data by risk factor that is helpful in understanding the role of injection drug use on health. Missouri School Survey data for 2006–2008 gave a glimpse of general **youth trends** in current and lifetime use of some of the major substances. Data from the NMAPSS project and the Prescription Drug Use, Misuse, and Depression Study conducted by the Washington University Epidemiology and Prevention Research Program were used to address an important knowledge gap on adolescent drug trends in our area. **Death data** from the St. Louis City and County Medical Examiner for the first 6 months of CYs 2008–2009 provided insight to the extent that drug use results in death, along with basic demographic data helpful to understanding emerging trends. Ongoing reports of **drug use, price, and purity** from the Drug Enforcement Administration and the National Drug Intelligence Center are invaluable, as are the frequent formal written reports and anecdotal insight provided by the staff of these agencies.

Drug Abuse Patterns and Trends in San Diego County—Update: January 2010

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Overview of Findings: Methamphetamine use and abuse indicators continued their decline in San Diego County since peaking in 2005, but changes in price and availability warrant careful monitoring. Most cocaine indicators declined in the first half of 2009, compared with the prior year. Most marijuana indicators increased, compared with the prior year. Heroin indicators were mixed. Narcotic analgesic and MDMA (3,4-methylenedioxymethamphetamine)/ecstasy indicators were mostly stable.

Updated Drug Abuse Trends and Emerging Patterns: Methamphetamine continued as a drug of substantial concern in San Diego County, but most indicators suggested its use and abuse were continuing to decrease since peaking in 2005. Primary substance abuse treatment admissions for methamphetamine accounted for 30 percent ($n=2,195$) of all admissions in the first half of 2009, compared with 32 percent ($n=2,401$) in the first half of 2008. Prevalence of use among male and female adult arrestees in 2008 was 20 and 31 percent, respectively, compared with 24 and 44 percent in 2007. There were 83 drug overdose deaths involving amphetamine (including methamphetamine) in 2008, compared with 98 in 2007. Finally, the estimated number of Drug Abuse Warning Network (DAWN) weighted emergency department (ED) visits involving methamphetamine decreased by 29 percent from 2006 to 2008 (2,297 versus 1,625). These downward trends in methamphetamine use and abuse have paralleled an increase in the price of large quantity street purchases; for example, the street price for a pound of methamphetamine increased from \$6,000–\$10,000 in 2005 to \$10,000–\$20,000 in 2007. In 2008, however, the street price per pound dropped to \$8,000–\$15,000, suggesting changes in the methamphetamine market that may subsequently influence use. Concurrently, the proportion of San Diego County adult arrestees who reported in the Substance Abuse Monitoring Program sponsored by the San Diego Association of Governments (SANDAG) that methamphetamine was more available in the past year almost doubled,

from 17 percent in 2007 to 31 percent in 2008. Most **cocaine/crack** indicators suggested reductions in use and abuse. Prevalence of use among male, female, and juvenile arrestees in 2008 was 8, 12, and 2 percent, respectively, compared with respective percentages of 11, 16, and 3 in 2007. Primary cocaine treatment admissions decreased to 408 in the first half of 2009, from 527 in the first half of 2008; the former represented 6 percent of all treatment admissions, compared with 7 percent in 2008. Further, 10 percent of drug seizures in the first half of 2009 tested positive for cocaine, compared with 13 percent in calendar year 2008. In contrast, most **marijuana** indicators suggested increases in use and abuse. Primary marijuana treatment admissions increased from 18 percent of total treatment admissions in the first half of 2008, to 21 percent in 2009. Although not statistically significant, the estimated number of marijuana-involved DAWN ED visits was 1,622 in 2007 and 2,067 in 2008. Fifty-four percent of drug items seized and identified in forensic laboratories tested positive for marijuana/cannabis in the first half of 2009, up slightly from 52 percent in 2008. However, female adult arrestees recorded a 9-year low for marijuana prevalence, at 26 percent. **Heroin** indicators were mixed; primary heroin treatment admissions decreased by 4 percent from 2008 to 2009, but there was a statistically significant 65-percent increase in the estimated number of heroin-involved ED visits from 2007 to 2008. Other heroin indicators remained stable. Narcotic analgesic indicators were low and remained stable, as did MDMA/ecstasy indicators.

Data Sources: *Arrestee data* were from the SANDAG Substance Abuse Monitoring program, a regional continuation of the Federal Arrestee Drug Abuse Monitoring program that was discontinued in 2003. This report presents 2008 data for both adult ($n=767$) and juvenile ($n=159$) arrestees. *Forensic laboratory data* were from the National Forensic Laboratory Information System, Drug Enforcement Administration. There were 11,120 drug items analyzed by local forensic laboratories between January and June 2009. **Treatment data**

came from the San Diego Department of Alcohol and Drug Programs (ADP) (tables produced by the California Department of ADP) using the California Outcomes Measurement System (CalOMS). CalOMS is a statewide client-based data collection and outcomes measurement system for alcohol and other drug (AOD) prevention and treatment services. Submission of admission/discharge information for all clients is required of all counties and their subcontracted AOD providers, all direct contract providers receiving public AOD funding, and all private-pay licensed narcotic treatment providers. Data for this report include admissions to San Diego County for the period January–June 2009. Note that CalOMS was implemented in early 2006 (replacing the earlier CADDIS system). Therefore, data reported for periods prior to July 2006 may not be comparable to more recent periods. **ED data** for 2004–2008 are weighted estimates of visits from DAWN, administered by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, which samples non-Federal hospitals operating 24-hour EDs. The completeness of data reported by participating EDs varies by month. A full description of the DAWN data system can be found at <http://dawninfo.samhsa.gov/>. **Mortality data** were obtained from the Emergency Medical Services Medical Examiner Database, which is maintained by the County of San Diego Health and Human Services Agency.

Drug Abuse Patterns and Trends in the San Francisco Bay Area—Update: January 2010

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Overview of Findings: Economic conditions worsened considerably in the San Francisco Bay area during 2009, especially in the east bay

counties (Alameda and Contra Costa). Cocaine treatment admissions were slightly up, estimated cocaine-involved emergency department (ED) visits were down, and drugs seized and identified as cocaine were down. Heroin indicators were level or slightly up after a steep decline, albeit with a worrisome increase in younger users. Methamphetamine indicators continued to decline. Little change was seen in marijuana usage in this reporting period, and “club drugs” were not a serious concern.

Updated Drug Abuse Trends and Emerging Patterns: Treatment admissions for **cocaine** continued gradually to increase from fiscal years (FYs) 2007 and 2008 through 2009. However, weighted Drug Abuse Warning Network (DAWN) ED estimated cocaine-involved visits in 2008 were only 28.6 percent of all estimated drug visits in calendar year (CY) 2008, as compared with 35.2 percent in 2006. Wholesale prices of cocaine rose between 2006 and 2008. **Heroin** indicators showed a continued gradual increase in treatment admissions from FYs 2007 and 2008 through 2009. That drug’s proportion of all ED estimated visits fell steadily, from 18.9 percent of all visits in 2004 to 11.1 percent in 2008. Prices at the wholesale and retail level were dropping. All indicators of **methamphetamine** use (admissions, methamphetamine-involved ED visits, and wholesale price affordability) continued slowly to decline. However, estimated ED visits involving methamphetamine increased from 2007 to 2008 in the 45–54 age group. Little change was seen in **marijuana** indicators, but a small increase in estimated marijuana-involved ED visits of younger users (18–24) was noted from 2007 to 2008. Areas of the east bay appeared to have heavy users of **oxycodone and hydrocodone**. Drugs seized and identified as containing those two prescription opiates rose slightly between 2008 and the first half of 2009 (oxycodone from 2.9 to 3.2 percent of total drugs identified; hydrocodone from 2.4 to 2.6 percent). With the possible exception of **MDMA** (3,4-methylenedioxymethamphetamine), indicators were neither large nor increasing for any club drugs in the bay area. **HIV/AIDS Update:** Acquired

immunodeficiency syndrome (AIDS) cumulative reports in San Francisco County increased by 6.7 percent among heterosexual injection drug users (IDUs), and by 8.1 percent among gay/bisexual male IDUs, in the 5 years to September 2009. The former group still comprised only 7 percent of the total San Francisco caseload.

Data Sources: *Treatment admissions data were available for all five bay area counties for FYs 2007 and 2008 and were provided by the California Department of Alcohol and Drug Programs. Admissions data for FYs 2008 and 2009 were provided for San Francisco by that county's Community Substance Abuse Programs. Weighted ED DAWN data from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, were available from 2004 through 2008 for the three counties of the west bay area (San Francisco, San Mateo, Marin). Price and purity data came from the Drug Enforcement Administration, Heroin Domestic Monitor Program, and referenced heroin "buys" mostly made in San Francisco County. Data for 2008 were compared with those for 2001–2007. Data on trafficking in heroin and other drugs were available from the National Drug Intelligence Center and pertained to wholesale, mid-level, and retail prices prevailing in San Francisco in June 2008. Reports of drugs seized and identified were provided by the National Forensic Laboratory Information System for 2008 and the first half of 2009. AIDS surveillance data were provided by the San Francisco Department of Public Health and covered the period through September 30, 2009.*

Drug Abuse Patterns and Trends in Seattle, Washington—Update: January 2010

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Overview of Findings: Overall, the 6 months worth of data reported on for the first half of 2009 were inadequate for trend analyses. Cocaine, marijuana, heroin, pharmaceutical opioids, and methamphetamine all persisted as major drugs of abuse. A range of other drugs were used at lower levels. Of note, it appeared that the first slight decline in drug-caused deaths involving pharmaceutical opioids since 1999 occurred in the first half of 2009.

Updated Drug Abuse Trends and Emerging Patterns: The number and types of drugs of involved in drug-caused deaths remained fairly steady from 2008 to the first half of 2009 overall. **Cocaine** was the most common illegal drug, identified in 27 of 125 drug-caused deaths; however, it was identified in fewer deaths than were pharmaceutical opioids, alcohol, and benzodiazepines. For adults, treatment admissions overall have increased approximately 50 percent since 1999. Admissions for cocaine have doubled since 1999 among adults, although they dropped a bit in the first half of 2009, compared with 2007 and 2008. **Alcohol** remained the most common drug among adults entering treatment. Drug Abuse Warning Network (DAWN) emergency department (ED) reports for the Seattle area for the first half of 2009 indicated that cocaine was the most common illegal drug reported, with 1,680 reports. **Heroin** was the second most common illegal drug in ED reports, with 1,202. Heroin drug treatment admissions have held relatively steady since 1999 in terms of absolute numbers. Likely heroin/opiate deaths remained steady, with heroin/opiate identified in 20 percent of drug-caused deaths in the first half of 2009. The first slight decline in drug-caused deaths involving **pharmaceutical opioids** appeared to have occurred in the first half of 2009. The most common pharmaceutical opioids continued to be methadone and oxycodone. The number

and proportion of pharmaceutical opioid treatment admissions increased continuously from 2003 to the first half of 2009, although they remained less common than admissions for the other major drugs of abuse. The nonmedical use of pharmaceutical opioids totaled 2,229 ED reports, more than any illegal drug, and there were 1,020 reports for **benzodiazepines**. Benzodiazepines were present in more than one in four drug-caused deaths and are almost always detected in combination with other drugs. The number of drug treatment admissions for youth has remained steady overall since 1999, with **marijuana** continuing to represent the majority of admissions; alcohol was second. ED reports for marijuana totaled 1,039. **Methamphetamine** treatment admissions have held fairly steady since 2005, despite the switch to Mexico for the production of the majority of locally consumed methamphetamine. Methamphetamine ED reports totaled 536. Statewide data for methamphetamine indicated its presence in deaths for samples tested by State forensic laboratories, all causes and manners, increased from 178 to 209 from 2008 to calendar year (CY) 2009. Over this same period, DUIs (Driving Under the Influence) in which methamphetamine was detected increased slightly to 354, and total clandestine laboratories remained steady at a low level, with 38 in CY 2009. **Other drugs** included cathinone (from khat, a plant native to East Africa and the Arabian Peninsula), reported for the first time in testing of local law enforcement evidence, with 14 pieces of evidence identified as positive (although it has been reported in the Seattle area for several years). The proportion of cases identified as positive for **BZP** (1-benzylpiperazine) increased from none in 2007 to 3 percent ($n=38$) in the first half of 2009. Less commonly reported substances included phencyclidine (**PCP**) ($n=113$) and **MDMA** (3,4-methylenedioxymethamphetamine) ($n=77$).

Data Sources: *Drug overdose data were obtained from the King County Medical Examiner, Public Health—Seattle & King County for the first half of 2009. Data on seized drug samples submitted for analysis were obtained from the National*

Forensic Laboratory Information System (NFLIS), DEA, for January–June 2009. Drug testing results for law enforcement seizures in King County were reported by the county where the drug was seized. ED drug report data were obtained from DAWN Live!, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, for the first half 2009. Data were accessed December 10, 2009. Data completeness for the first half of 2009 was as follows: 14 to 19 of the EDs reported basically complete data (90 percent or greater) each month, and 3 to 7 reported no data out of 25 eligible EDs. Drug treatment data were provided by Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, Treatment Report and Generation Tool, from 1999 through June 2009. Treatment modalities included outpatient, intensive inpatient, recovery house, long-term residential, and opiate substitution admissions. Department of Corrections and private-pay admissions were included. Methamphetamine incident, DUI, and fatality data were provided by the Washington State Patrol Forensic Laboratory Services Bureau.

Drug Abuse Patterns and Trends in Texas—Update: January 2010

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Overview of Findings Presented in Slide Presentation at the Meeting: The slide presentation/update for Texas looked at Texas data for cocaine, heroin, methamphetamine, marijuana, PCP (phencyclidine), ecstasy, and prescription drugs, including methadone and buprenorphine. It also looked at various national and international data sources to give a broader overview of possible reasons for changes at the State level. The abuse of methadone or buprenorphine in combination

with pharmaceutical drugs was examined, and the increases in BZP (1-benzylpiperazine) were shown. In addition, the preliminary findings from the author's study of methamphetamine markets in the Austin, Texas, area were presented.

Data Sources: Data sources included U.S. Treatment Episode Data Set (TEDS) data for 1993–2007, preliminary Texas TEDS data for 1987–2009, Texas and RADARS poison control calls, preliminary National Forensic Laboratory Information System data for Texas Department of Public Safety laboratories and national data through 2009, Texas death data through 2006, STRIDE (a database sent to Drug Enforcement Administration [DEA] laboratories) data from DEA through the first half of 2009, Texas school survey data through 2008, National Survey on Drug Use and Health data for 2006–2008, national Drug Abuse Warning Network data for 2004–2008, Automation of Reports and Consolidated Orders System data through 2008, and the DEA report from the June 2009 meeting. In addition, other data are included from Cunningham J.K., Liu L.M., Callaghan R. *Impact of US and Canadian precursor regulation on methamphetamine purity in the United States* (2009). *Addiction*; 104, 441–453, and Maxwell, J.C. & McCance-Katz, E.F. (in press). *Indicators of buprenorphine and methadone use and abuse: What do we know? American Journal on the Addictions*, and findings from the initial interviews with methamphetamine users in *Monitoring the Changing Methamphetamine Market in the Austin Area*, NIDA, R21 DA025029.

INTERNATIONAL REPORTS: CANADA, THE CARIBBEAN, AND EUROPE

The Drug Situation in Canada— Health Canada's Update: January 2010

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Overview of Findings: Cannabis continued to be the dominant illicit drug in Canada, both from self-reported past-year use and from laboratory analysis of exhibits from seized substances. Among the general population age 15 and older, approximately 1–2 percent reported using other illicit drugs (e.g., cocaine/crack cocaine, speed, hallucinogens, and ecstasy). The number of exhibits analyzed for seizures of methamphetamine, prescription opioids, prescription sedatives, prescription stimulants, and prescription pain relievers appeared to have increased over the past year.

Updated Drug Abuse Trends and Emerging Patterns: Results from the Canadian Alcohol and Drugs Use Monitoring Survey (CADUMS) indicated that 11 percent of Canadians age 15 and older reported past-year **cannabis** use. This is a decrease from the 14 percent measured in the 2004 Canadian Addictions Survey. When past-year cannabis use was examined by province, the only decrease was measured in British Columbia (13 percent in 2008, compared with 17 percent in 2004). Self-reported past-year use of other illicit drugs (e.g., **cocaine/crack cocaine, speed, hallucinogens, and ecstasy**) ranged between 1 and 2 percent in 2008. No significant changes were seen in any other illicit drug use since 2004, except for hallucinogens. The past-year use of hallucinogens increased from less than 1 percent in 2004 to 2 percent in 2008; however, the addition of items (e.g., *Salvia divinorum* and magic mushrooms) to the list of substances considered to be hallucinogens in 2008 made interpretation of these results difficult. In 2008, 28 percent of Canadians age 15 and older indicated that they had used (including for medical use) a **pharmaceutical drug** (e.g., **opioid pain reliever**,

stimulant, sedative, or tranquilizer) in the past year. Among these users, 2 percent reported that they used such a drug to get high (this represents less than 1 percent of the Canadian population). Results from Health Canada's Drug Analysis Service (DAS) Laboratory Information Management System (LIMS) indicated that the vast majority of exhibits analyzed from substances seized by police and border services were **cannabis**, followed by **cocaine** (cocaine and crack cocaine). Although the number of cannabis exhibits examined had declined compared with 2004, there was a slight increasing trend in the number of exhibits analyzed since 2005. After year-over-year increases in cocaine exhibits analyzed (2003–2007), slightly fewer cocaine exhibits were analyzed in 2008. With the exception of Quebec, all regions in Canada showed a slight increase in the number of cocaine exhibits since the mid-1990s. Overall, Ontario had the highest number of cocaine exhibits. Until 2004, all regions except the Atlantic region, which had a small number of exhibits, had a similar volume of exhibits of **methamphetamine** analyzed by the DAS laboratories. Since that time, the number of exhibits in Ontario had more than doubled, while a steady and more moderate increase was noted in Quebec. Since the mid-2000s, there appeared to be a decline in the number of methamphetamine exhibits analyzed in the western part of the country (Prairies and British Columbia). All regions have shown an increase in **MDMA** (3,4-methylenedioxymethamphetamine) since the late 1990s, with the largest increase found in Ontario and Quebec. Most **heroin** exhibits submitted for testing have been seized in British Columbia. Regardless of the region, heroin exhibits peaked in 1999 and decreased since 2000. Since the mid-2000s, there has been a rebound in the number of heroin exhibits being analyzed in British Columbia (2004) and Ontario (2006). Since 2000, there has been a sixfold increase in the number of **prescription opioid** exhibits analyzed (e.g., **hydromorphone**, **morphine**, **codeine**, **oxycodone**, **methadone**, and **fentanyl**) in Ontario. All other regions have shown an increase, although not as marked. A comparison between suspected

substances, as identified by police services, and the results of the laboratory analysis of exhibits, found that in 2008, 97 percent of the substances seized and suspected to be cannabis were in fact cannabis; this has not changed over the last 5 years (period of analysis). Only two-thirds (68 percent) of cocaine exhibits were determined to be cocaine; this is a decline from the peak in 2006, when 79 percent of suspected cocaine exhibits were, upon laboratory analysis, determined to be cocaine. A similar pattern was seen for heroin exhibits (47 percent in 2003 to 42 percent in 2008); methamphetamine exhibits (75 percent in 2004 to 55 percent in 2008); and MDMA exhibits (28 percent in 2004 to 21 percent in 2008).

Data Sources: Survey data: *In April 2008, Health Canada implemented the first ongoing survey on alcohol and illicit drug use in Canada, the CADUMS. Prior to the launch of this survey, the monitoring of alcohol, illicit drugs, and other substances had been based on occasional surveys. The availability of ongoing surveillance data will help to provide current information, monitor trends over time, and reduce some of the potential biases, including seasonal biases that can be particularly strong for alcohol, and possibly drug, use. CADUMS is an ongoing general population telephone-based survey of people age 15 and older. The data are analyzed on an annual basis, starting with data from 2008. Residents from all provinces are included, but not those in the territories. The main objectives to be addressed by the core set of questions on an ongoing basis in the survey are twofold: to determine the prevalence and frequency of alcohol, cannabis, and other substance use in the Canadian population age 15 and older; and to measure the extent of harms which are associated with the use of alcohol and other drug use. Data limitations include the potential underreporting of drug use. Drug seizure data: In Canada, the DAS of Health Canada is responsible for analyzing suspected controlled substances that are seized by Canadian police officers and custom agents for prosecutorial purposes. The tests confirm the identity, and in some cases the purity, of*

the substances seized and result in certificates of analysis that are used as evidence in Canadian courts. The results of these analyses are retained in a computerized national database, known as LIMS. The database holds results for more than 1,932,160 analyses conducted from January 1988 to the present. In 2008 alone, more than 134,130 samples were analyzed by DAS. Seizure data are affected by the extent, focus, and effectiveness of interception/detection activities by police and border services, (e.g., a targeted crackdown on methamphetamine will increase the number of arrests but does not necessarily indicate increased presence or use of that drug). Also in Canada, laboratory analyses of seized drugs are only carried out for cases with “not guilty” pleas (i.e., incomplete set of data, or representativeness needs to be established).

The Revitalization of the Canadian Community Epidemiology Network on Drug Use

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The Canadian Centre on Substance Abuse (CCSA) is working on a plan to revitalize the Canadian Community Epidemiology Network on Drug Use (CCENDU). Established in 1995, the CCENDU at one time had 12 sites with annual national reports coordinated by CCSA; only 3 sites remain active today. There has been no activity at the national level for several years. Despite the value that people recognize in the CCENDU, numerous obstacles exist in the re-establishment of a national community surveillance network, such as consistent funding, commitment, and continuity. Recently, a plan was prepared with specific actions to address these obstacles. The philosophy behind this plan is to “do it right or don’t do it at all.” The plan includes help to support existing

sites with special projects and start-up funds that could be leveraged for additional local funding. The revitalized CCENDU would also play a vital role in the National Surveillance Strategy, with community-level data feeding into and complementing both provincial and national data. Networking continues to be a pivotal component, with efforts to foster ongoing communication between sites as well as with the United States’ National Institute on Drug Abuse’s CEWG. The CCSA is optimistic about the plans to revitalize CCENDU to create a vibrant national community drug surveillance network in Canada.

Data Source: CCSA, Ontario, Canada

Research and Information on Drugs in the Caribbean—The Inter-American Drug Abuse Control Commission

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Introduction: This report introduces members of the CEWG to work being done by the Organization of American States (OAS) through its antidrug agency, the Inter-American Drug Abuse Control Commission (CICAD), in the Caribbean. The OAS has 34 member States, and of this number 14 are considered to be from the Caribbean. The organization of statistics on drugs is not as developed as it is in other regions in the world, and in mid-2008 CICAD initiated a project with some member States to help them consolidate their drug information by developing drug information networks. Some of the results of this work, along with the results of epidemiological research, will help paint a picture about drugs in the region.

Production: In general terms, the Caribbean region is not a major source of drugs, and

only two countries are recognized as exporters of marijuana. Several of the countries, especially those with good air linkages to North America and Europe, are used as transshipment points for traffickers moving their product from South America. Most drug seizures, arrests, and prosecutions in the Caribbean are related to marijuana and cocaine.

Drug Abuse Trends: The results of recent surveys indicate the following:

- Marijuana is the most widely used illicit drug.
- Marijuana use is higher than tobacco use in students in several of the countries surveyed.
- Prevalence rates for cocaine and other illegal substances are generally low.
- The prevalence rates of inhalant use in some of the countries surveyed were quite high when compared with other countries in other regions (including the United States).
- Among students who currently drank alcohol, binge drinking was an issue. There was, however, some variability from country to country, with binge drinking rates ranging from about 25 to 50 percent.
- Some countries have unique problems. Haiti, for example, has a problem with the nonmedical use of pharmaceuticals because of lax regulations and poor enforcement and oversight.

Treatment data in the region are very limited, but data from four countries show very clearly that the primary drugs for which people seek treatment vary widely from country to country. In Antigua, marijuana is the primary drug, and it accounts for 70 percent of their treatment admissions. Grenada reports that polydrug use (without cocaine) is the main problem in 40 percent of their admissions. In Suriname, crack cocaine accounts for 81 percent of admissions. In Haiti, alcohol accounts for about one-half of all treatment admissions. The caveat here is that the way these data are recorded, the way clinical decisions are made, and the types of treatment available vary from country to country.

The quantity of drug-related data and information from the Caribbean is very limited, but steps are being taken to improve this situation; concrete results are beginning to emerge. One objective that CICAD is currently pursuing is the development of a system similar to the CEWG for the Caribbean region.

Data Source: *CICAD, OAS, Washington, DC*

Monitoring Drug Use in Europe— European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)—Update: January 2010

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Background: Established in 1993 as one of the decentralized technical agencies of the European Community, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) acts as the central reference point for drug information in Europe. Data are collected through a network of national focal points (Reitox) located in all 27 European Union (EU) member states, the candidate countries Croatia and Turkey, and Norway by special agreement. Data are collected annually through a set of structured tools. Areas of interest for monitoring activities span epidemiology and health statistics, activities in drug demand, and drug supply reduction, as well as policy and legal developments. The agency produces an annual assessment of the state of the drug situation in the EU, which is published in 23 languages. This is supported by extensive online resources, which include a statistical bulletin, national reports, special studies, and contextual information. In addition to annual reporting of standardized information through the Reitox network, the EMCDDA coordinates, together with Europol, the European

early warning system on new psychoactive substances. This event-based reporting system tracks the emergence of new substances on the European drug market and can trigger a formal risk assessment process, which may result in control measures being adopted across the EU.

Update on Drug Abuse Trends and Emerging Patterns: The most recent assessment of the European drug situation was released in November 2009, and this report draws heavily on this analysis. Around 22 percent (74 million) of European adults report lifetime **cannabis** use; last year prevalence (LYP) is estimated at around one-third of this figure (22 million). Intensive (daily or near daily) use can be cautiously estimated, based on a restricted data set, at just over 1 percent of all adults (4 million). Surveys of both the general and youth populations suggest that overall levels of cannabis use are falling. This change appears particularly pronounced in younger age cohorts and in higher prevalence countries. New treatment demands for cannabis have been rising for some time, but they appear to be leveling off. This trend has been partially but not exclusively driven by directive referrals. Trends in intensive use are more difficult to estimate, and it remains unclear if there has been any decline in this pattern of use. In terms of the number of users, **cocaine** is the second most commonly consumed drug in the EU. However, this reflects the high prevalence found in a relatively restricted group of countries, principally Spain, the United Kingdom, Italy, Ireland, the Netherlands, and Denmark. Elsewhere in Europe, and particularly in Eastern Europe, cocaine use remains uncommon. Overall estimates of LYP for cocaine use in the EU currently stand at 4 million adults, or about 1.2 percent of the adult population. However, in high-prevalence countries, estimates of recent use are similar to those reported in the United States. Trends in cocaine use are difficult to assess, as indicators are not consistent. Surveys still report increases in prevalence, and other data suggest that the use of the drug may be beginning to diffuse more widely in Europe. While the number of seizures is still increasing, the volume seized

peaked in 2006 and has fallen since then. The price of the drug appears also to be falling, as does the purity of the cocaine available in some major European markets. Crack cocaine use remains rare and geographically limited to a few locations within the inner cities of a small number of countries. Until 2004, indicators pointed to a declining **heroin/opioid** problem in the EU, with evidence of an aging population increasingly in contact with treatment services. This picture was somewhat different in Eastern European countries where heroin problems had developed later. Recent data are less easy to interpret but point to an overall stable, rather than declining situation. Of concern, seizures and new treatment demands show slight increases, and opioid drug-related deaths continue to rise. In terms of overall trends, the use of **amphetamine** appears to be declining or stable in most countries, with some evidence of cocaine displacing amphetamine in some areas. **Methamphetamine** use still remains relatively restricted. The use of **ecstasy** remains overall stable, but there is a more volatile and diverse synthetic drug market. Precursor availability appears to be affecting patterns of synthetic drug use in Europe. In the ecstasy market, up to 2007, most tablets sold as ecstasy contained **MDMA** (3,4-methylenedioxymethamphetamine) or a close analogue. However, in 2009, as much as one-half of the ecstasy tablets sold in some markets appear to contain mCPP (1-(m-chlorophenyl)piperazine). This drug is not listed under the United Nations conventions. The reason for this change is suspected to be a shortage of a main precursor chemical for ecstasy production—PMK (3-4-methylenedioxyphenyl-2-propanone). Precursor availability as well as market developments may also be impacting on the availability of methamphetamine in Europe, although the use of this drug still remains rare. Historically, methamphetamine problems in the EU have been restricted to the Czech Republic, where a local market has existed since the Communist era. However, during the 2000s the use of the drug spread to neighboring Slovakia. The most recent analysis suggests that a small but increasing number of methamphetamine production sites are now located outside of

these countries and significant production is taking place on the eastern border of the EU. Seizure data also suggest that methamphetamine is now becoming increasingly available in Nordic countries with long established amphetamine problems. Human immunodeficiency virus (**HIV**) infections related to injection drug use remain low in Europe, and less than one-half (42 percent) of new heroin users entering treatment now report injecting. **New Drugs/Emerging Issues:** More than 100 substances are being monitored by the

EU early warning system on new drugs. In 2008 and 2009, for the first time a number of new synthetic cannabinoids were identified that had been surreptitiously added to herbal mixtures available predominantly through Internet-based suppliers. To date, 10 new synthetic cannabinoids have been identified. During 2009, increasing reports of synthetic cathinones have been received and these are currently being investigated.

Data Source: EMCDDA, Lisbon, Portugal

Section IV. Across CEWG Areas: Treatment Admissions, Forensic Laboratory Analysis Data, Weighted Emergency Department Data, and Average Price and Purity Data

Cocaine/Crack

- Treatment admissions data for the first half of 2009 revealed that primary cocaine treatment admissions, including primary alcohol admissions, did not rank first in frequency among any CEWG areas, but ranked second in 1 of the 23 reporting CEWG areas: Miami/Dade County (section II, table 2).
- Cocaine was the drug most frequently identified by forensic laboratories in 7 of 22 reporting CEWG areas in the first half of 2009. Based on forensic laboratory analysis of drug items identified in the first half of 2009, cocaine/crack ranked first in three of the five areas in the southern region (Atlanta, Miami, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and two of eight areas in the western region (Denver and San Francisco). In none of the CEWG areas in the midwestern region did cocaine rank first. However, it ranked second in four of the five areas in the midwestern region (Chicago, Cincinnati, Detroit, and St. Louis) in frequency of drug items identified (section II, table 1 and figure 27; appendix table 2).
- Based on weighted DAWN data, estimated numbers and rates of ED visits involving cocaine increased significantly in 4 of 11 CEWG reporting areas between 2004 and 2008, namely Boston, Denver, Detroit, and New York City. From 2007 to 2008, 5 of the 11 CEWG reporting areas had declines in weighted cocaine ED visits and visit rates: Boston, Denver, Detroit, New York City, and Phoenix (figure 29; appendix table 3.1).

Treatment Admissions Data on Cocaine/Crack

Table 3 presents the most recent data from 23 CEWG sites/areas on primary cocaine treatment admissions as a proportion of total admissions, including those for alcohol (see also appendix table 1). In all cases, the reporting period covers the first half of 2009, January through June 2009.

Miami/Dade County had the highest percentage (32.2 percent) of primary cocaine admissions, as a proportion of total admissions, in the 2009

reporting period, followed distantly by San Francisco and Philadelphia (21.7 and 21.6 percent, respectively), and Chicago, Detroit, and Texas (with respective percentages of 18.9, 18.5, and 18.4). The lowest proportions of primary cocaine treatment admissions, including primary alcohol admissions, were observed for Hawaii (3.1 percent) and Maine (4.5 percent) (table 3).

Based on treatment admissions for the first half of 2009, including those for primary alcohol problems, cocaine did not rank first among any

Table 3. Primary Cocaine Treatment Admissions in 23 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: 1H 2009^{1,2}

CEWG Areas	Primary Cocaine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	754	2,429	31.0	4,683	16.1
Baltimore	1,210	7,146	16.9	8,661	14.0
Boston	694	6,580	10.5	9,627	7.2
Chicago	4,759	19,415	24.5	25,197	18.9
Cincinnati	466	2,253	20.7	3,379	13.8
Colorado	1,358	8,414	16.1	14,457	9.4
Denver	661	3,762	17.6	6,040	10.9
Detroit	776	3,011	25.8	4,192	18.5
Ft. Lauderdale/Broward County	331	1,720	19.2	2,313	14.3
Hawaii	177	3,895	4.5	5,730	3.1
Los Angeles	3,590	19,822	18.1	25,346	14.2
Maine	270	3,408	7.9	5,980	4.5
Maryland	3,604	21,348	16.9	32,301	11.2
Miami/Dade County	667	1,589	42.0	2,069	32.2
Minneapolis/St. Paul	665	4,834	13.8	10,315	6.4
New York City	6,932	29,092	23.8	40,713	17.0
Philadelphia	1,725	6,098	28.3	7,969	21.6
Phoenix	139	1,377	10.1	2,166	6.4
St. Louis	825	3,710	22.2	5,771	14.3
San Diego	408	5,895	6.9	7,389	5.5
San Francisco	2,048	7,207	28.4	9,448	21.7
Seattle	1,001	4,631	21.6	7,533	13.3
Texas	8,577	33,939	25.3	46,643	18.4

¹More information on these data is available in the footnotes and notes for table 2 and appendix table 1.²Data are for January–June 2009.³Percentages of primary cocaine admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

SOURCE: January 2010 State and local CEWG reports

CEWG areas, but it ranked second in 1 of the 23 reporting CEWG areas: Miami/Dade County (section II, table 2).

Forensic Laboratory Data on Cocaine/ Crack

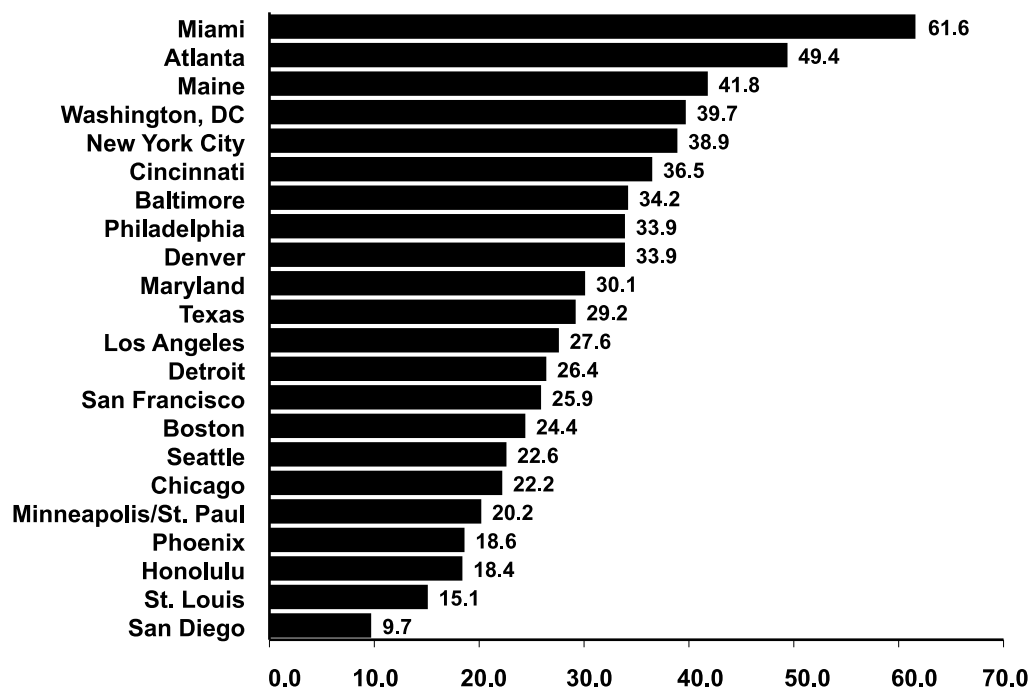
Based on rankings shown in section II, table 1, in 7 of the 22 reporting CEWG areas, cocaine ranked as the most frequently identified drug in forensic laboratories in the first half of 2009. These were three of the five southern region CEWG areas (Miami, Atlanta, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and two of eight areas in the western region (Denver and San Francisco). Cocaine ranked first among drug items identified in none of the CEWG areas in the midwestern region. However, it ranked second in four of the five areas in the midwestern region: Chicago, Cincinnati, Detroit, and St. Louis. Among the other 11

areas in which cocaine ranked second in identified drug items in the 2009 reporting period were Baltimore and Maryland; Boston and Philadelphia; and Los Angeles, Seattle, and Texas in the southern, northeastern, and western regions, respectively (section II, table 1 and figure 21; appendix table 2). Cocaine items as a percentage of the total drug items reported in the NFLIS system were particularly high in the Miami/Dade MSA (61.6 percent), followed by Atlanta (49.4 percent). The lowest reported frequencies of cocaine drug items among those identified in forensic laboratories were in San Diego and St. Louis, at 9.7 and 15.1 percent, respectively (figure 22; appendix table 2).

Weighted DAWN Estimates of ED Visits Involving Cocaine, 2004–2008

Estimated numbers and rates of ED visits involving cocaine increased significantly in 4 of 11 CEWG reporting areas between 2004 and 2008,

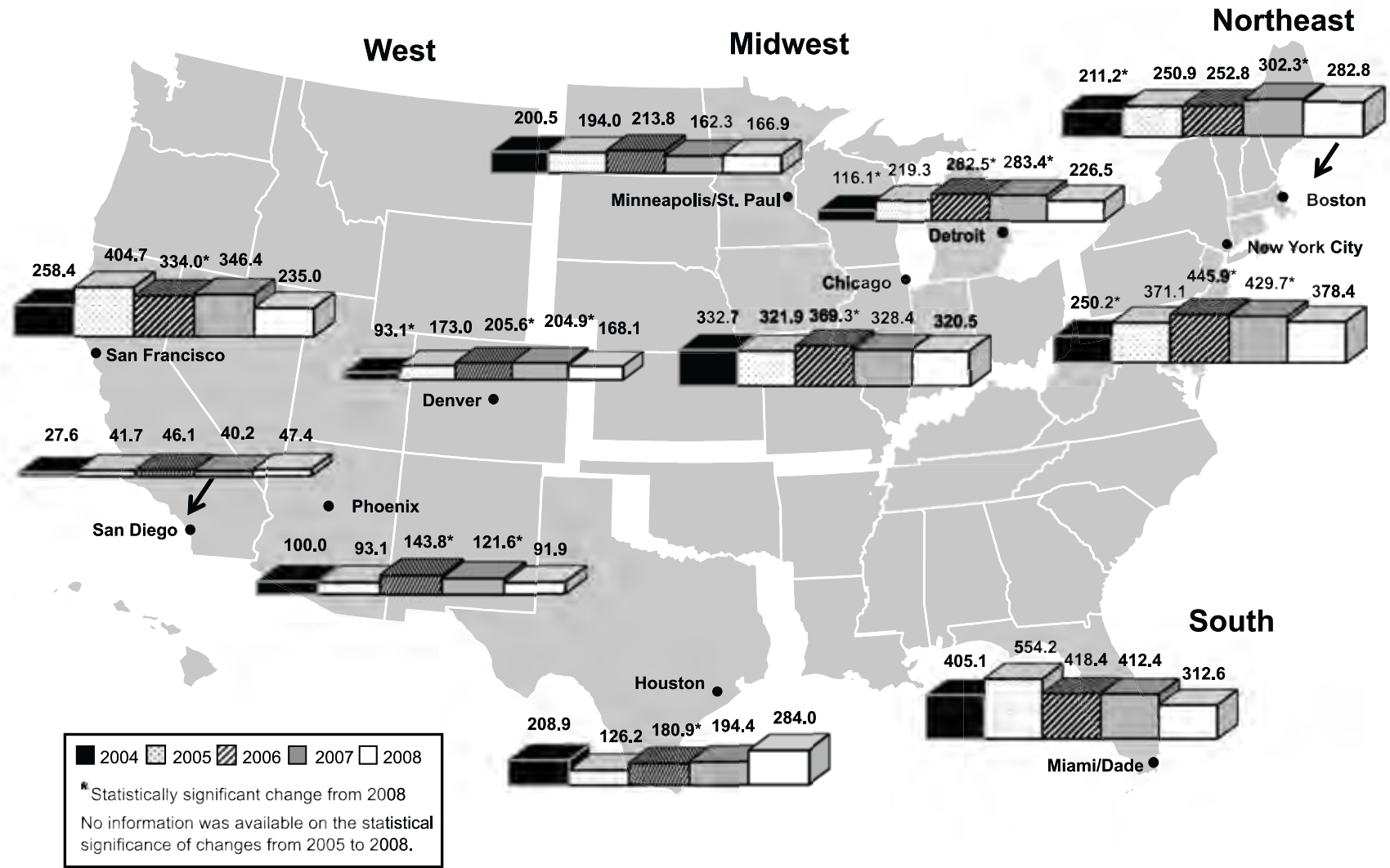
Figure 22. Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2009¹



¹Data are for the first half of 2009: January–June 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22

Figure 23. Weighted Estimates of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Cocaine¹ as Rates per 100,000 Population², for 11 CEWG Areas: 2004–2008



¹These are weighted estimates of cocaine-involved visits based on a representative sample of non-Federal, short-term hospitals with 24-hour emergency departments (EDs) in the United States.

²Rates per 100,000 population for cocaine are calculated based on total cocaine-involved visits including those for all case types; the population data are from the U.S. Census County-Level Population Estimates (CPOP) file.

SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 4, 2009; data are subject to change (see appendix table 3.1)

namely Boston, Denver, Detroit, and New York City. Estimated visits involving cocaine increased by approximately 95 and 92 percent over the period in Detroit and Denver, respectively. In New York City and Boston, the approximate increases were 55 and 36 percent, respectively. In the period

from 2007 to 2008, 5 of the 11 CEWG reporting areas had declines in weighted cocaine ED visits and visit rates: Boston, Denver, Detroit, New York City, and Phoenix. Declines ranged from 6 percent in Boston to 22 percent in Phoenix during this 1-year period (figure 23; appendix table 3.1).

Heroin

- Heroin primary treatment admissions, as a percentage of total admissions including primary alcohol admissions, were particularly high in Baltimore (approximately 51 percent) and Boston (approximately 50 percent) in the first half of 2009 (table 4). In 5 of 23 CEWG areas—Baltimore, Boston, Chicago, Detroit, and San Francisco—heroin was the substance most frequently reported as the primary problem at treatment admission in the reporting period. Heroin ranked second in treatment admissions in New York City and Maryland (section II, table 2; appendix table 1).
- In 11 of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in the first half of 2009. Proportions were highest in Baltimore and Maryland (approximately 25 and 20 percent, respectively). They were lowest in Atlanta, Honolulu, and Minneapolis/St. Paul, at approximately 1–2 percent of drug items identified in each area (figure 30; appendix table 2). Heroin was not ranked first in drug items seized in any CEWG area, although it was ranked second in one area—Maine (section II, table 1).
- Statistically significant changes in weighted DAWN ED reports and rates in 2008 compared with 2004 were noted for 5 of 11 reporting CEWG areas, consisting of increased estimated ED visits involving heroin in 3 areas—Denver, Detroit, and Phoenix—and decreased visits 1 area—San Francisco (figure 31; appendix table 3.2).
- Data from the HDMP suggest that for CY 2008, South American heroin continued to be the primary source of heroin east of the Mississippi River, as has been the case since the mid-1990s. Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi. Average purity levels for SA heroin increased in 4 of 10 CEWG areas (Atlanta, Chicago, Miami, and Baltimore) from 2007 to 2008; they remained stable in one area, Boston, and declined in 5 other areas—Chicago, Detroit, New York City, Philadelphia, St. Louis, and Washington, DC. Average prices for South American heroin fell in 6 of 10 CEWG areas (Atlanta, Baltimore, Chicago, Detroit, New York City, and Philadelphia) and rose in 4 (Boston, Miami, St. Louis, and Washington, DC) (table 5). From 2007 to 2008, Mexican heroin average purity declined in 7 of 11 CEWG areas, namely Dallas, Houston, Los Angeles, Minneapolis, San Diego, San Francisco, and Seattle, while average purity increased slightly in three areas (El Paso, Phoenix, and San Antonio), and remained constant in one area (Denver) (table 6). The average price was lower or the same in 2008, compared with 2007, in 6 of 11 reporting CEWG reporting areas (Dallas, Denver, Minneapolis, Phoenix, San Antonio, and San Francisco) and was higher in 5 areas (El Paso, Houston, Los Angeles, San Diego, and Seattle).

Treatment Admissions Data on Heroin

In this reporting period (the first half of 2009) for 18 of 22 CEWG areas, primary heroin treatment admissions as a proportion of total admissions for substance abuse treatment, including primary alcohol admissions, ranged from approximately 2 to 51 percent. After Baltimore at 51.0 percent, Boston

had the highest proportion of heroin admissions, at 50.1 percent of all admissions (table 4). The lowest percentage of primary heroin admissions, after Hawaii (1.9 percent), was in Ft. Lauderdale/Broward County in South Florida (2.0 percent). When all admissions, including those for whom alcohol was the primary drug, are examined, heroin ranked

Table 4. Primary Heroin Treatment Admissions in 23 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: 1H 2009^{1,2}

CEWG Areas	Primary Heroin Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	181	2,429	7.5	4,683	3.9
Baltimore	4,414	7,146	61.8	8,661	51.0
Boston	4,822	6,580	73.3	9,627	50.1
Chicago	9,596	19,415	49.4	25,197	38.1
Cincinnati	524 ⁴	2,253	23.3	3,379	15.5
Colorado	793	8,414	9.4	14,457	5.5
Denver	485	3,762	12.9	6,040	8.0
Detroit	1,461	3,011	48.5	4,192	34.9
Ft. Lauderdale/Broward	47	1,720	2.7	2,313	2.0
Hawaii	107	3,895	2.7	5,730	1.9
Los Angeles	4,517	19,822	22.8	25,346	17.8
Maine	555	3,408	16.3	5,980	9.3
Maryland	8,131	21,348	38.1	32,301	25.2
Miami/Dade County	64	1,589	4.0	2,069	3.1
Minneapolis/St. Paul	672	4,834	13.9	10,315	6.5
New York City	10,618	29,092	36.5	40,713	26.1
Philadelphia	1,159	6,098	19.0	7,969	14.5
Phoenix	300	1,377	21.8	2,166	13.9
St. Louis	1,240	3,710	33.4	5,771	21.5
San Diego	1,367	5,895	23.2	7,389	18.5
San Francisco	3,189 ⁴	7,207	44.2	9,448	33.8
Seattle	839	4,631	18.1	7,533	11.1
Texas	5,727	33,939	16.9	46,643	12.3

¹More information on these data is available in the footnotes and notes for table 2 and appendix table 1.

²Data are for January–June 2009.

³Percentages of primary heroin admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

⁴Heroin and other opiates are grouped together for Cincinnati and San Francisco and are reported in this heroin table only.

SOURCE: January 2010 State and local CEWG reports

first in 5 of 23 CEWG areas—Baltimore, Boston, Chicago, Detroit, and San Francisco. Heroin ranked second in Maryland and New York City and third in Cincinnati and St. Louis (section II, table 2).

Forensic Laboratory Data on Heroin

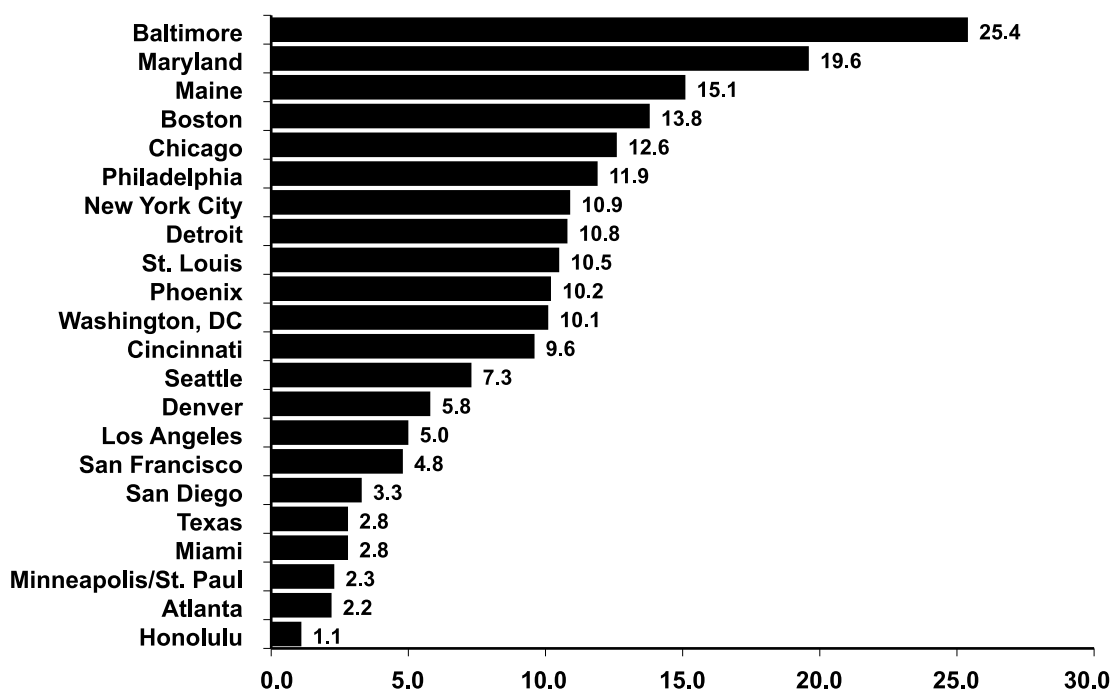
In 11 of the 22 CEWG areas shown on the map in figure 21 (section II) and in figure 24 below, heroin items accounted for less than 10 percent of the total drug items reported by NFLIS. The exceptions were Baltimore, Maryland, Maine, Boston, Chicago, Philadelphia, New York City, Detroit, St. Louis, Phoenix, and Washington, DC. As a proportion of total drug items, heroin items were highest in Baltimore (25.4 percent) and Maryland (19.6 percent), compared with other CEWG areas. Heroin drug items identified were lowest in Minneapolis/St. Paul, Atlanta, and Honolulu, at 2.3, 2.2, and 1.1 percent, respectively (figure 24; appendix table 2).

Heroin was not ranked as the number one most frequently identified drug in any of the CEWG areas in the first half of 2009 (section II, table 1). It appeared as second in the rankings of drug items identified in that reporting period in only one area, Maine. Heroin ranked third in 11 of 22 reporting areas, in four of five areas in the South (the exception is Atlanta where it ranked eighth); three of four northeastern areas (Boston, New York City, and Philadelphia); four of five midwestern areas with the exception of Minneapolis/St. Paul, where it ranked fifth; and in none of the eight areas in the western region. There heroin ranked between fourth and sixth.

Weighted DAWN Estimates of ED Visits Involving Heroin, 2004–2008

Estimated heroin-involved ED visits and associated rates per 100,000 population increased significantly in 3 of 11 CEWG reporting areas

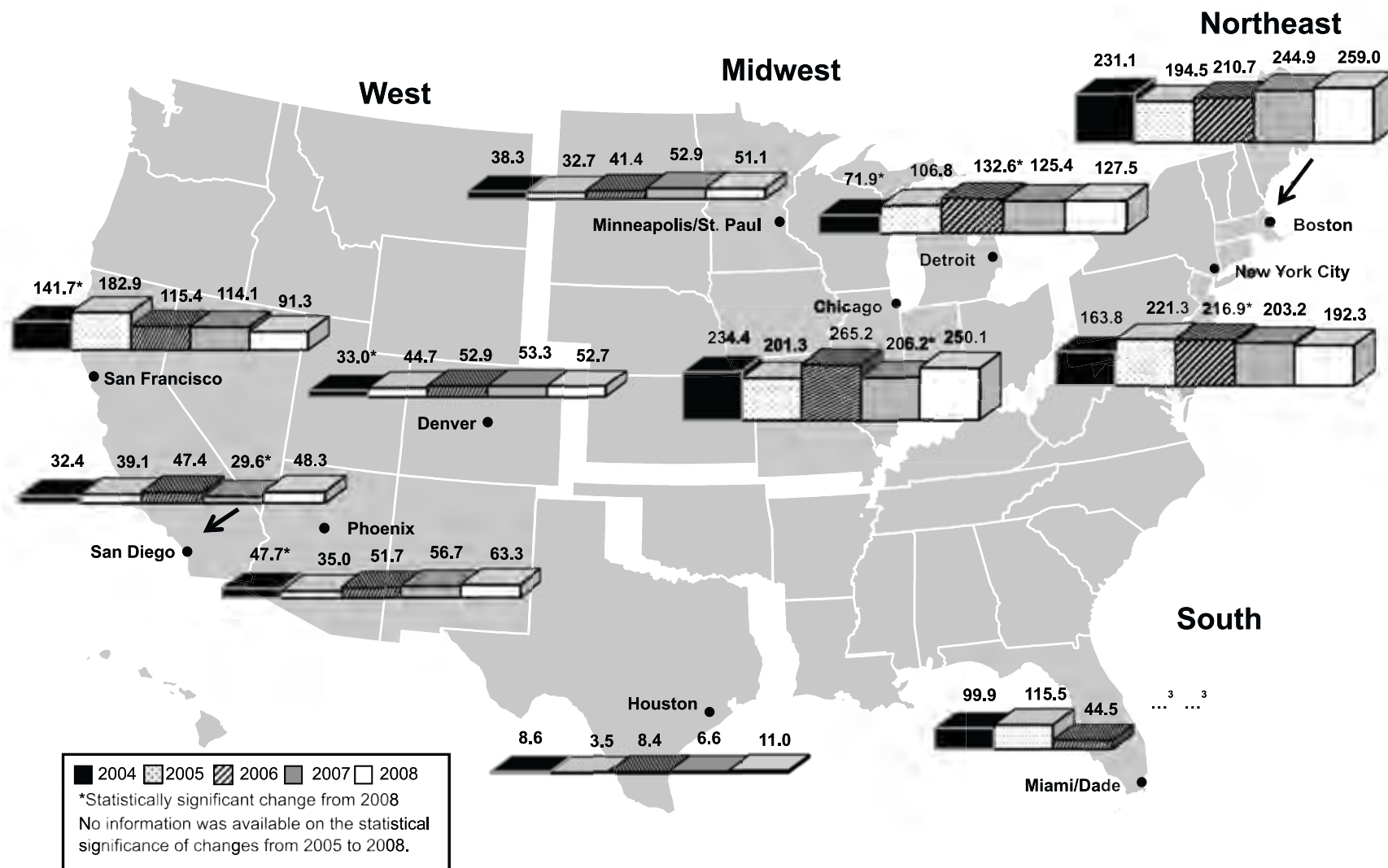
Figure 24. Heroin Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2009¹



¹Data are for first half of 2009: January–June 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22

Figure 25. Weighted Estimates of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Heroin¹ as Rates per 100,000 Population², for CEWG Areas: 2004–2008



¹These are weighted estimates of heroin-involved visits based on a representative sample of non-Federal, short-term hospitals with 24-hour emergency departments (EDs) in the United States.

²Rates per 100,000 population for heroin are calculated based on total heroin-involved visits including those for all case types; the population data are from the U.S. Census County-Level Population Estimates (CPOP) file.

³Three dots (...) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count less than 30 has been suppressed.

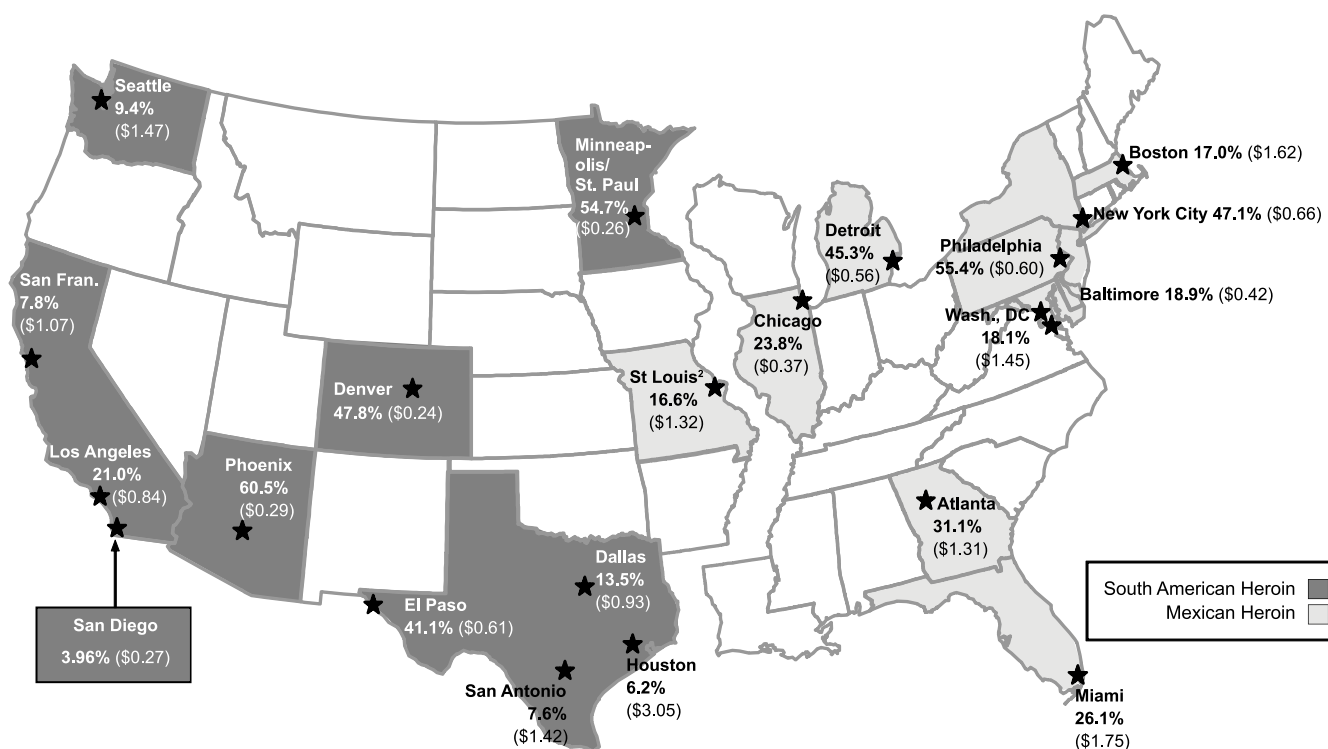
SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 4, 2009; data are subject to change (see appendix table 3.2)

between 2004 and 2008, namely Detroit, Denver, and Phoenix, and decreased significantly in 1 area, San Francisco. Estimated ED visits involving heroin increased by 74, 72, and 53 percent over the 5-year period in Detroit, Denver, and Phoenix, respectively. In San Francisco, the decline in ED visits was reported at 33 percent over the period. No other CEWG areas showed significant changes in rates or visits between 2004 and 2008 (figure 25; appendix table 3.2). However, two areas, Chicago and San Diego, experienced increases of 22 and 65 percent, respectively, in the one-year period from 2007 to 2008.

Heroin Domestic Monitor Program (HDMP) Price and Purity Data

The map below (figure 26) depicts the most recent data on the average price per milligram pure and the average percentage of heroin purity across CEWG areas, as reported by the DEA's HDMP for 2008. Data from the HDMP suggest that for CY 2008, SA heroin continued to be the primary source of heroin east of the Mississippi River, as has been the case since the mid-1990s. Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi. Data shown here are confined to SA and Mexican heroin, since the availability of Southwest Asian heroin was limited

Figure 26. Heroin Domestic Monitor Program—Average Heroin Purity and Average Price Per Milligram Pure by Predominant Source in CEWG Areas¹: 2008



¹Not included here are some types, e.g., Southeast and Southwest Asian heroin. Where both South American (SA) and Mexican heroin purchases were made, the more prevalent drug source identified is reported as predominant.

²In St. Louis, Mexican heroin was the predominant source in 2006, unlike 2005, 2007, and 2008 when SA heroin samples were more frequently identified. Therefore, while data are reported for St. Louis in tables 6 and 7 for both forms of heroin, only SA heroin average price and purity data are represented on this map.

SOURCE: DEA, 2008 HDMP Drug Intelligence Report, published October 2009, pp. 5–6

in the CEWG areas where it was reported—Atlanta, Baltimore, Detroit, and Washington, DC—and no Southeast Asian heroin was purchased in the HDMP program in 2008, as in 2006 and 2007.

Table 5 reports average percent purity and average price per milligram pure of SA heroin in 10 CEWG cities for the period 2005–2008. In 2008, average purity levels for SA heroin ranged from 16.6 percent in St. Louis to 55.4 percent in Philadelphia. From 2007 to 2008, these levels increased in 4 of 10 CEWG areas (Atlanta, Chicago, Miami, and Baltimore), in contrast to Boston, where average purity levels remained stable, and 5 other areas—Detroit, New York City, Philadelphia, St. Louis, and Washington, DC—where heroin purity declined. Among the CEWG areas with declining

average purity, St. Louis and New York City represented the largest declines of between 2 and 4 percentage points during the period.

Over the 1-year period from 2007 to 2008, average prices for SA heroin fell in 6 of 10 CEWG areas (Atlanta, Baltimore, Chicago, Detroit, New York City, and Philadelphia) and rose in 4 (Boston, Miami, St. Louis, and Washington, DC) (table 5). Average 2008 heroin prices ranged from a low of \$0.37 in Chicago to a high of \$1.75 in Miami. The largest price increase for 2008 was in St. Louis, at an average of around \$.50 per milligram pure.

Data on results of purchases of Mexican black tar heroin are presented in table 6 for another 11 CEWG areas, where this form of heroin predominates in the drug markets (figure 26). The highest

Table 5. Average Percent Purity and Average Price in Dollars of South American (SA) Heroin in 10 CEWG Areas: 2005–2008

CEWG Areas	2005 Avg. Purity (%)	2005 Avg. Price (\$)	2006 Avg. Purity (%)	2006 Avg. Price (\$)	2007 Avg. Purity (%)	2007 Avg. Price (\$)	2008 ¹ Avg. Purity (%)	2008 ¹ Avg. Price (\$)
Atlanta	39.3	\$2.04	39.1	\$2.34	29.1	\$1.89	31.1	\$1.31
Baltimore	29.1	\$0.54	31.0	\$0.46	18.1	\$0.60	18.9	\$0.42
Boston	29.4	\$0.88	18.2	\$1.63	17.0	\$1.37	17.0	\$1.62
Chicago	17.1	\$0.45	12.6	\$0.49	22.4	\$0.45	23.8	\$0.37
Detroit	46.6	\$0.76	41.4	\$0.76	46.0	\$0.98	45.3	\$0.56
Miami	19.4	\$1.36	24.4	\$1.75	18.1	\$1.48	26.1	\$1.75
New York City	49.4	\$0.46	44.5	\$0.67	49.0	\$0.79	47.1	\$0.66
Philadelphia	54.9	\$0.58	54.9	\$0.63	56.3	\$0.71	55.4	\$0.60
St. Louis ²	28.3	\$1.00	17.6	\$1.22	21.0	\$0.80	16.6	\$1.32
Washington, DC	20.2	\$0.95	11.7	\$1.42	19.5	\$1.34	18.1	\$1.45

¹The following number of samples form the basis for 2008 averages: Atlanta, 12; Baltimore, 23; Boston, 34; Chicago, 19; Detroit, 25; Miami, 18; New York City, 45; Philadelphia, 31; St. Louis, 9; and Washington, DC, 16. One sample of Mexican heroin was reported for Washington, DC.

²In 2005, SA rather than Mexican heroin emerged for the first time as the predominant form of heroin in St. Louis. However, in 2006, Mexican heroin reestablished itself as the predominant form. In 2007 and 2008, SA heroin was again the predominant form purchased in St. Louis. Therefore, while data are reported for St. Louis in both SA heroin and Mexican heroin tables (tables 5 and 6), only St. Louis SA heroin purchases are discussed in the text. Price and purity data for 2008 were reported by the DEA for SA heroin for two additional CEWG areas, but results were based on samples of only 1 or 2 samples. These areas are Minneapolis (with two samples reporting purity at 44.3 percent and average price at \$0.56) and San Diego (with one sample reporting purity at 66.1 percent and average price at \$0.42).

SOURCE: DEA, 2008 HDMP Drug Intelligence Report, published October 2009

purity levels were reported in 2008 in Phoenix and Minneapolis (60.5 and 54.7 percent, respectively), and the lowest were reported in Houston, at 6.2 percent.

From 2007 to 2008, Mexican heroin average purity declined in 7 of 11 CEWG areas, namely Dallas, Houston, Los Angeles, Minneapolis, San Diego, San Francisco and Seattle, with the largest decline in Seattle (approximately 10 percentage points). Average purity increased slightly in three areas (El Paso, Phoenix, and San Antonio), and it remained constant in one area (Denver) (table 6).

The average price per milligram pure of Mexican black tar heroin ranged in 2008 from a low of \$0.24 in Denver to a high of \$1.47 in Seattle. The average price was lower or the same in 2008, compared with 2007, in 6 of 11 reporting CEWG reporting areas (Dallas, Denver, Minneapolis, Phoenix, San Antonio, and San Francisco), and it was higher in 5 areas (El Paso, Houston, Los Angeles, San Diego, and Seattle). The largest increase of \$1.39 per kilogram pure was seen in Houston, with average prices nearly doubling over the 1-year period in both Houston and Los Angeles (table 6).

Table 6. Average Percent Purity and Average Price of Mexican Heroin per Milligram Pure in 11 CEWG Areas¹: 2005–2008

CEWG Areas ¹	2005 Avg. Purity (%)	2005 Avg. Price (\$)	2006 Avg. Purity (%)	2006 Avg. Price (\$)	2007 Avg. Purity (%)	2007 Avg. Price (\$)	2008 ² Avg. Purity (%)	2008 ² Avg. Price (\$)
Dallas	11.6	\$1.11	17.7	\$1.10	20.6	\$1.09	13.5	\$0.93
Denver	44.3	\$0.42	45.3	\$0.30	47.6	\$0.28	47.8	\$0.24
El Paso	44.7	\$0.40	44.8	\$0.33	39.8	\$0.49	41.1	\$0.61
Houston	23.7	\$1.14	18.1	\$1.90	7.0	\$1.66	6.2	\$3.05
Los Angeles	31.1	\$0.33	24.7	\$0.33	24.0	\$0.32	21.0	\$0.84
Minneapolis	NR ³	NR ³	52.4	\$0.27	59.9	\$0.29	54.7	\$0.26
Phoenix	53.1	\$0.22	45.4	\$0.36	56.9	\$0.31	60.5	\$0.29
San Antonio	11.2	\$0.56	17.4	\$0.79	7.1	\$1.88	7.6	\$1.42
San Diego	55.9	\$0.15	48.6	\$0.37	43.7	\$0.20	39.6	\$0.27
San Francisco	12.3	\$0.89	9.7	\$0.69	8.1	\$1.28	7.8	\$1.07
Seattle	10.8	\$1.23	10.9	\$1.48	19.5	\$1.12	9.4	\$1.47

¹South American heroin was the most dominant form of heroin reported in 2005, 2007, and 2008 in St. Louis, while Mexican heroin predominated in that area in 2006. Therefore, Mexican heroin purchase data are not included in this table and are not discussed in the text. St. Louis respective purity and price data are as follows: 15.9% and \$1.47 in 2005; 19.5% and \$0.99 in 2006; 3.1% and \$6.95 in 2007; and 3.6% and \$4.87 in 2008.

²The following number of samples form the basis for 2008 averages: Dallas, 37; Denver, 25; El Paso, 16; Houston, 38; Los Angeles, 36; Minneapolis, 13; Phoenix, 35; San Diego, 35; San Francisco, 38; and Seattle, 32. St. Louis' data were based on seven samples of Mexican heroin, with nine samples of South American heroin. Two samples of South American heroin were reported for Minneapolis, and one sample was reported for San Diego.

³NR is data are not reported.

SOURCE: DEA, 2008 HDMP Drug Intelligence Report, published October 2009

Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

- In the first half of 2009, treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 1 to approximately 9 percent in 19 of 20 reporting CEWG areas. The outlier was Maine, where nearly 32 percent of primary treatment admissions were for other opiate problems (table 7; appendix table 1).
- While none of the 20 CEWG areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, other opiates ranked second in Maine and third in Minneapolis/St. Paul (section II, table 2).
- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in the first half of 2009. In Boston, Cincinnati, Maine, Maryland, and Philadelphia, oxycodone ranked fourth in drug items identified, and it ranked fifth in five other CEWG areas—Atlanta, Baltimore, New York City, Phoenix, and Seattle (section II, table 1). Hydrocodone ranked fourth in drug items identified in Atlanta and Detroit and fifth in Cincinnati and Texas (section II, table 1; table 8).
- Buprenorphine ranked fourth in identified NFLIS drug items in Baltimore, fifth in Boston and Maryland, seventh in Maine and Seattle; and it was tied for eighth place in Washington, DC, in the first half of 2009 (section II, table 1; table 8).
- Methadone ranked in the top 10 identified drugs in New York City (7th); San Francisco (8th); Baltimore, Cincinnati, Honolulu, Maine, and Maryland (9th each); and Boston (10th) during this reporting period (section II, table 1; table 8).
- Between 2004 and 2008, estimated ED visits involving nonmedical use of opiate/opioid drugs other than heroin increased significantly in all 11 CEWG DAWN reporting areas. From 2007 to 2008, these visits increased in 7 areas—Chicago, Denver, Detroit, Minneapolis/St. Paul, Phoenix, San Diego, and San Francisco (figure 27; appendix table 3.3).

Treatment Admissions Data on Opiates/Opioids

In the 2009 reporting period (the first half of 2009), 20 CEWG areas provided data on treatment admissions for primary abuse of opiates other than heroin as a category separate from heroin. Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from less than 1 to approximately 9 percent in 19 of the 20 reporting CEWG areas. Including primary alcohol admissions, the other opiates admissions group accounted for a high of

31.7 percent of the primary treatment admissions in one other area, Maine. This was followed distantly by Maryland and Minneapolis/St. Paul, where 9.1 and 7.5 percent, respectively, of total primary treatment admissions were for other opiates. At the low end, other opiates accounted for from 0.5 to 1.4 percent of total admissions in Chicago and New York City (table 7). While none of the CEWG areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions (section II, table 2), in Maine other opiates ranked second, while this drug category ranked third in Minneapolis/St. Paul.

Table 7. Primary Other Opiate Treatment Admissions in 20 CEWG Areas¹ as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: 1H 2009^{2,3}

CEWG Areas ¹	Primary Other Opiates Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁴		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	230	2,429	9.5	4,683	4.9
Baltimore	297	7,146	4.2	8,661	3.4
Boston	448	6,580	6.8	9,627	4.7
Chicago	128	19,415	0.7	25,197	0.5
Colorado	731	8,414	8.7	14,457	5.1
Denver	294	3,762	7.8	6,040	4.9
Detroit	106	3,011	3.5	4,192	2.5
Ft. Lauderdale/Broward	144	1,720	8.4	2,313	6.2
Los Angeles	573	19,822	2.9	25,346	2.3
Maine	1,896	3,408	55.6	5,980	31.7
Maryland	2,946	21,348	13.8	32,301	9.1
Miami/Dade County	40	1,589	2.5	2,069	1.9
Minneapolis/St. Paul	771	4,834	15.9	10,315	7.5
New York City	578	29,092	2.0	40,713	1.4
Philadelphia	180	6,098	3.0	7,969	2.3
Phoenix	77	1,377	5.6	2,166	3.6
St. Louis	157	3,710	4.2	5,771	2.7
San Diego	290	5,895	4.9	7,389	3.9
Seattle	356	4,631	7.7	7,533	4.7
Texas	2,862	33,939	8.4	46,643	6.1

¹One CEWG area not included in the table due to lack of availability of treatment admissions data for the reporting period is Hawaii, while two other areas, San Francisco and Cincinnati, were not included here because heroin and other opiates are grouped together. Data for these areas are included in primary heroin treatment admissions counts and tables only.

²More information on these data is available in the footnotes and notes for table 2 and appendix table 1.

³Data are for January–June 2009.

⁴Percentages of primary other opiates admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

SOURCE: January 2010 State and local CEWG reports

Forensic Laboratory Data on Opiates/Opioids (Narcotic Analgesics)

Of the narcotic analgesic/opiate items identified by forensic laboratories across CEWG areas in the first half of 2009, oxycodone and hydrocodone were the two most frequently reported in most areas. However, they rarely accounted for more than 6 percent of all drug items identified in any area (table 8; appendix table 2).

Oxycodone. Maine reported the highest frequency of oxycodone items identified in forensic laboratories in the period (at 8.6 percent), followed by Boston (6.5 percent) and Seattle (5.6 percent) (table 8). Oxycodone ranked fourth in drug items identified in Maryland, Boston, Maine, Philadelphia, and Cincinnati (section II, table 1). It ranked fifth in frequency of drug items identified in forensic laboratories in five other CEWG areas—Atlanta, Baltimore, New York City, Phoenix, and Seattle (section II, table 1). In 6 of 22 CEWG areas, oxycodone represented less than 1 percent of the total drug items identified in forensic laboratories in the reporting period (table 8).

Hydrocodone. Hydrocodone ranked fourth in drug items identified in Atlanta and Detroit and fifth in Cincinnati and Texas (section II, table 1). Identified percentages of drug items containing hydrocodone ranged from 4.2 percent in Detroit and 4.1 percent in Atlanta to less than 1.0 percent in 10 of 22 areas reporting in the first half of 2009 (table 8). Ten other areas had from 1.2 percent (Seattle) to 3.5 percent (Texas) of NFLIS hydrocodone items.

Buprenorphine. Baltimore, Boston, Maine, Maryland, and Seattle were the only CEWG areas with at least 1 percent of drug items identified containing buprenorphine. Percentages were 1.4, 2.5, 2.5, 1.3, and 1.2, respectively (table 8). According

to CEWG area reports reflected in section II, table 1, buprenorphine ranked fourth in identified drugs in Baltimore, fifth in Boston and Maryland, seventh in Maine and Seattle; and it was tied for eighth place in Washington, DC, in the first half of 2009 (section II, table 1).

Methadone. Maine, New York City, and San Francisco were the only areas reporting a percentage of 1 or higher for methadone drug items, at 2.0, 1.1, and 1.3 percent, respectively (table 8). Methadone ranked 7th in identified drugs in New York City; 8th in San Francisco; 9th in Baltimore, Cincinnati, Honolulu, Maine, and Maryland; and 10th in Boston during this reporting period (section II, table 1).

Weighted DAWN Estimates of Pharmaceutical Opiate/Opioid-Involved ED Visits, 2004–2008

Estimated numbers and rates of ED visits involving nonmedical use of opiates/opioids from 2004 through 2008 are shown in section IV, figure 27 and appendix table 3.3. This category includes all narcotic analgesics and other opiates not otherwise specified.

All 11 reporting areas experienced statistically significant increases in estimated ED visits involving nonmedical use of opiate pharmaceuticals over the 5-year period. Between 2004 and 2008, estimated ED visits involving the nonmedical use of opiates/opioids increased by highs of 250 percent in Denver and 176 percent in San Diego; they increased by a low of 28 percent in Chicago. Increases were also noted in seven areas in the 1-year period, 2007–2008—Chicago, Denver, Detroit, Minneapolis/St. Paul, Phoenix, San Diego, and San Francisco. Increases ranged between 10 percent (Detroit) and 59 percent (San Diego) (figure 27; appendix table 3.3).

Table 8. Selected Narcotic Analgesic Items Identified by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2009²

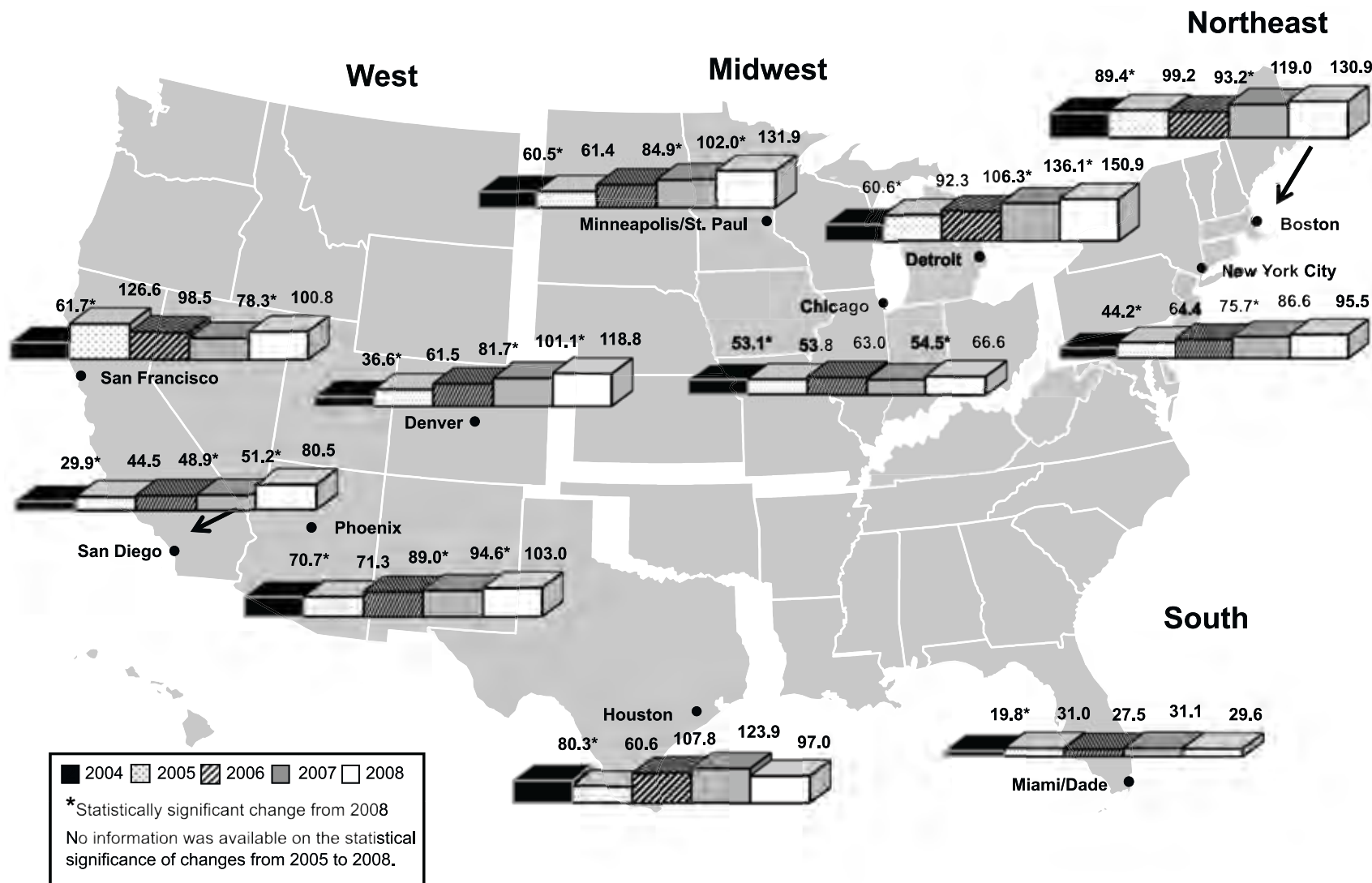
CEWG Area	Oxycodone		Hydrocodone		Methadone		Fentanyl		Buprenorphine		Total Items, All Drugs
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	
Atlanta	230	3.9	241	4.1	46	*	--	*	10	*	5,908
Baltimore	135	*	21	*	48	*	--	*	274	1.4	20,230
Boston	437	6.5	59	*	41	*	--	*	167	2.5	6,753
Chicago	58	*	269	*	55	*	--	*	49	*	42,018
Cincinnati	124	2.1	75	1.3	24	*	--	*	--	*	5,956
Denver	77	1.9	53	1.3	--	*	--	*	--	*	4,084
Detroit	36	*	206	4.2	6	*	2	*	11	*	4,870
Honolulu	2	*	1	*	4	*	--	*	--	*	735
Los Angeles	98	*	391	1.6	43	*	--	*	20	*	24,141
Maine	38	8.6	11	2.5	9	2.0	--	*	11	2.5	443
Maryland	446	1.5	83	*	83	*	--	*	368	1.3	29,245
Miami	148	1.1	37	*	6	*	--	*	7	*	13,106
Minneapolis/ St. Paul	39	1.9	16	*	8	*	--	*	6	*	2,020
New York City	520	1.8	214	*	327	1.1	--	*	141	*	29,147
Philadelphia	732	4.0	98	*	57	*	7	*	51	*	18,408
Phoenix	90	3.1	42	1.4	9	*	--	*	7	*	2,913
St. Louis	147	1.5	214	2.2	25	*	--	*	37	*	9,953
San Diego	148	1.3	204	1.8	53	*	--	*	34	*	11,120
San Francisco	297	3.2	248	2.6	122	1.3	--	*	12	*	9,424
Seattle	81	5.6	17	1.2	11	*	--	*	17	1.2	1,458
Texas	264	*	1,952	3.5	164	*	--	*	--	*	55,247
Washington, DC	21	1.3	2	*	3	*	--	*	14	*	1,643

¹Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol *.

²Data are for January–June 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

Figure 27. Weighted Estimates of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Nonmedical Use of Pharmaceutical¹ Opiates/Opioids as Rates per 100,000 Population², for 11 CEWG Areas: 2004–2008



¹These are weighted estimates of nonmedical use involving pharmaceutical opiate/opioid visits based on a representative sample of non-Federal, short-term hospitals with 24-hour emergency departments (EDs) in the United States.

²Rates per 100,000 population for opiates/opioids are based on total opiate/opioid-involved visits including those for all case types; the population data are from the U.S. Census County-Level Population Estimates (CPOP) file.

SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 4, 2009; data are subject to change (see appendix table 3.3)

Benzodiazepines/Depressants

- Atlanta and Texas had the highest percentages of alprazolam drug items identified in forensic laboratories in the first half of 2009, at 4.5 and 4.3 percent, respectively (table 9). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Atlanta; fourth in Miami, New York City, and Texas; fifth in Philadelphia; and sixth in Baltimore, Maryland, and Detroit (section II, table 1).
- Drug items containing clonazepam accounted for 2.2 percent of all drug items in Boston, where clonazepam figured as the sixth most frequently identified drug in forensic laboratories in the first half of 2009 (section II, table 1; table 9).
- Diazepam ranked 8th in Cincinnati and 10th in Philadelphia and Detroit among drug items identified in NFLIS forensic laboratories in the first half of 2009 (section II, table 1).
- Estimated ED visits involving nonmedical use of benzodiazepines increased significantly in 7 of the 11 reporting DAWN CEWG areas from 2004 to 2008. These were Boston, Chicago, Denver, Detroit, Minneapolis/St. Paul, New York City, and Phoenix. Significant increases in estimated ED visits and visit rates involving benzodiazepines in the 1-year period from 2007 to 2008 were experienced in five areas: Chicago, Detroit, Phoenix, San Diego, and San Francisco (figure 28; appendix table 3.4).

Treatment Admissions Data on Benzodiazepines

In most CEWG area treatment data systems, benzodiazepines are included with other depressants, barbiturates, and sedative/hypnotics; these admissions continued to account for small proportions of total treatment admissions. However, some CEWG areas noted that benzodiazepines or sedative/hypnotics were secondary or tertiary drugs of abuse among some treatment admissions.

Forensic Laboratory Data on Benzodiazepines

Three benzodiazepine-type items—alprazolam, clonazepam, and diazepam—were the most frequently reported benzodiazepines identified by forensic laboratories in 22 CEWG areas in the 2008 reporting period. Table 9 shows the numbers and percentages of drug items containing alprazolam, clonazepam, and diazepam in each of the reporting CEWG areas.

Alprazolam. In the 22 CEWG areas for which NFLIS data were reported for the first half of 2009, the highest percentages of alprazolam

drug items identified were in Atlanta (4.5 percent) and Texas (4.3 percent), followed by Philadelphia (3.6 percent), New York City (2.6 percent), and Miami (2.2 percent). Alprazolam drug items were reported at 1.0–1.9 percent in St. Louis, Detroit, Boston, and Phoenix, and at less than 1 percent in the remaining 13 reporting CEWG areas (table 9). In section II, table 1, which shows the rankings of the most frequently reported drugs in NFLIS for the first half of 2009 data, alprazolam ranked third in frequency among the top 10 drug items identified in Atlanta; fourth in three CEWG areas, Miami, New York City, and Texas; fifth in Philadelphia; and sixth in Baltimore, Maryland, and Detroit.

Clonazepam. Drug items containing clonazepam accounted for 2.2 percent of all drug items in Boston and 1.0 percent in Maine. Its presence was minimal in the 20 other CEWG areas (table 9). In Boston, clonazepam figured as the sixth most frequently identified drug in forensic laboratories in the first half of 2009. Clonazepam ranked seventh in Baltimore and Maryland and eighth in Philadelphia (section II, table 1).

Table 9. Number of Selected Benzodiazepine Items Identified by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2009²

CEWG Area	Alprazolam		Clonazepam		Diazepam		Total Items, All Drugs
	#	(%)	#	(%)	#	(%)	
Atlanta	267	4.5	33	*	29	*	5,908
Baltimore	103	*	67	*	19	*	20,230
Boston	97	1.4	146	2.2	34	*	6,753
Chicago	162	*	25	*	34	*	42,018
Cincinnati	54	*	21	*	39	*	5,956
Denver	24	*	14	*	19	*	4,084
Detroit	73	1.5	7	*	13	*	4,870
Honolulu	5	*	--	*	3	*	735
Los Angeles	175	*	61	*	80	*	24,141
Maine	--	*	3	*	3	*	443
Maryland	219	*	121	*	62	*	29,245
Miami	284	2.2	10	*	16	*	13,106
Minneapolis/St. Paul	11	*	10	*	10	*	2,020
New York City	762	2.6	185	*	82	*	29,147
Philadelphia	657	3.6	108	*	63	*	18,408
Phoenix	32	1.1	18	*	6	*	2,913
St. Louis	191	1.9	46	*	53	*	9,953
San Diego	105	*	63	*	56	*	11,120
San Francisco	41	*	94	1.0	78	*	9,424
Seattle	13	*	9	*	2	*	1,458
Texas	2,360	4.3	476	*	308	*	55,247
Washington, DC	6	*	--	*	--	*	1,643

¹Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol *.

²Data are for January–June 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

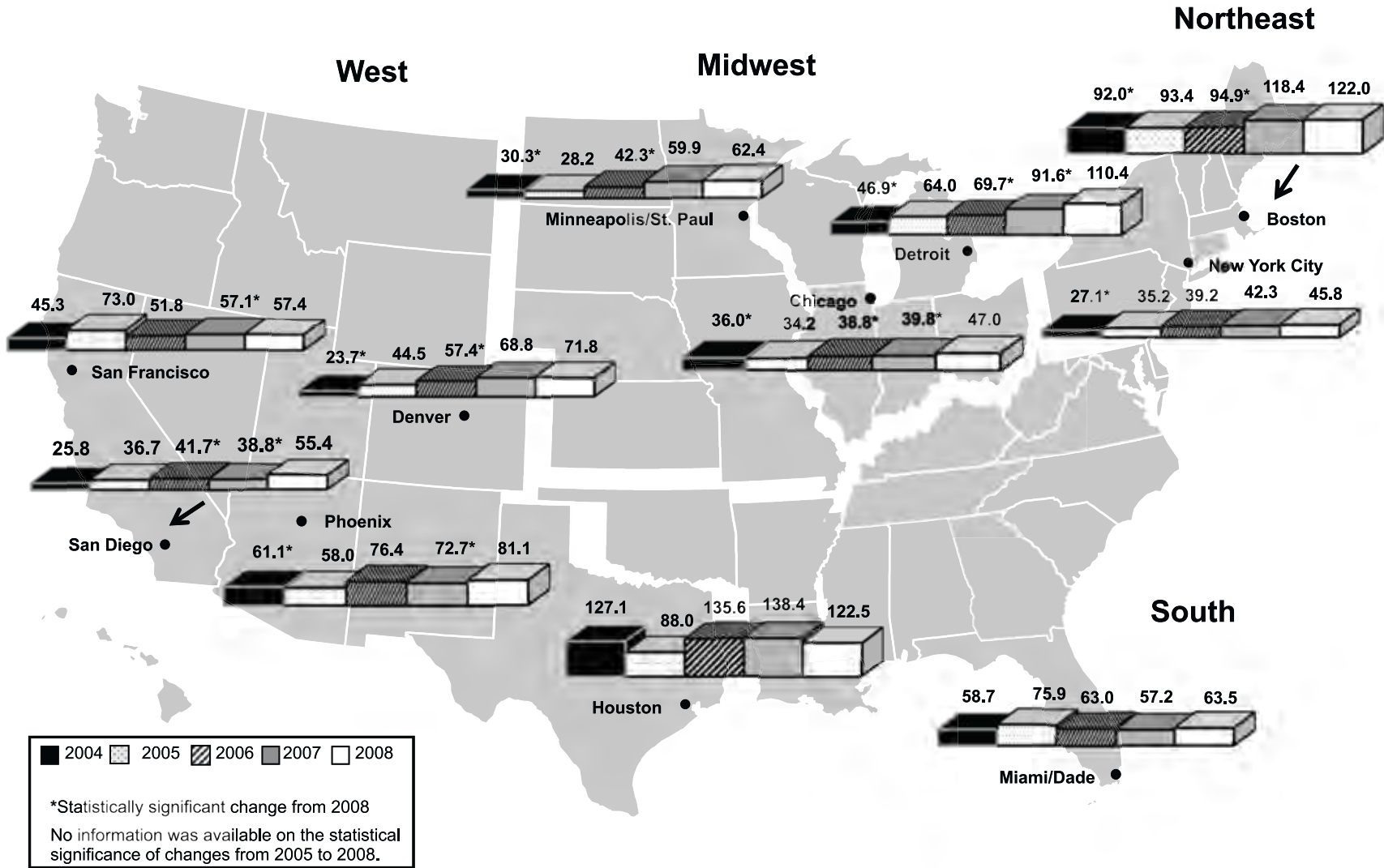
Diazepam. Drug items containing diazepam accounted for less than 1 percent of all drug items in each of the 22 CEWG areas (table 9). However, diazepam ranked 8th in Cincinnati and 10th in Philadelphia, Detroit, and San Diego among drug items identified in NFLIS forensic laboratories in the first half of 2009 (section II, table 1).

Weighted DAWN Estimates of ED Visits Involving Nonmedical Use of Benzodiazepines, 2004–2008

Estimated numbers and rates of ED visits involving nonmedical use of benzodiazepines for 11 CEWG areas for which weighted DAWN data were collected from 2004 through 2008 are shown in figure 28 and appendix table 3.4. Seven of the 11 reporting areas saw statistically significant increases in

estimated ED visits involving nonmedical benzodiazepine over the 5-year period. These areas were Boston, Chicago, Denver, Detroit, Minneapolis/St. Paul, New York City, and Phoenix. Between 2004 and 2008, estimated ED visits involving nonmedical use of benzodiazepines increased at the highest rate in Denver, by 227 percent, followed by Detroit, at 131 percent, and Minneapolis/St. Paul, at 114 percent. The range in increases for the other areas in 2004 to 2008 was from 34 percent (Chicago) to 73 percent (New York City). In the 1-year period from 2007 to 2008, five areas showed increases ranging from 2 to 45 percent in these estimated ED visits. They were Chicago, Detroit, Phoenix, San Diego, and San Francisco. Their respective percentage increases were 19, 20, 15, 45, and 2 percent (figure 28; appendix table 3.4).

Figure 28. Weighted Estimates of Emergency Department (ED) Visits Involving Nonmedical Use of Pharmaceutical Benzodiazepines¹ as Rates per 100,000 Population², for 11 CEWG Areas: 2004–2008



¹These are weighted estimates of benzodiazepine-involved visits based on a representative sample of non-Federal short-term hospitals with 24-hour emergency departments (EDs) in the United States.

²Rates per 100,000 population for benzodiazepines are calculated based on total benzodiazepine-involved visits including those for all case types; the population data are from the U.S. Census County-Level Population Estimates (CPOP) file.

SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 4, 2009; data are subject to change; see appendix table 3.4

Methamphetamine

- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine abuse in 13 reporting CEWG areas were especially high in Hawaii and San Diego, at approximately 37 and 30 percent, respectively. They were also relatively high in Phoenix and Los Angeles, with respective percentages of approximately 23 and 19 (table 10; appendix table 1).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego and Hawaii; second in Phoenix; third in Colorado, Denver, and Los Angeles; fourth in San Francisco; and fifth in Seattle, Texas, and Atlanta (section II, table 2).
- In the first half of 2009, methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu, second in Atlanta, Minneapolis/St. Paul, Phoenix, and San Diego, and third in five CEWG areas—Denver, Los Angeles, San Francisco, Seattle, and Texas (section II, table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 45 percent), followed by Minneapolis/St. Paul (approximately 28 percent), Atlanta (approximately 21 percent), Phoenix (approximately 20 percent), and San Diego (approximately 19 percent). In contrast, less than 1 percent of drug items identified as containing methamphetamine were reported in nine CEWG metropolitan areas east of the Mississippi, including Chicago, Boston, Detroit, New York City, Miami, Cincinnati, Philadelphia, Maryland, and Baltimore (figure 29; appendix table 2).
- Estimated numbers of ED visits involving methamphetamine increased 2 of the 11 reporting CEWG areas in the DAWN system, Boston and San Diego, and decreased 2 areas, San Francisco and Minneapolis/St. Paul, from 2004 to 2008. Respective increases were 123 and 10 percent, respectively, while respective decreases were 22 and 42 percent, respectively. In the period from 2007 to 2008, decreases in methamphetamine-involved ED visits were observed for one CEWG area, Denver (declining by 27 percent) (figure 30; appendix table 3.5).

Treatment Admissions Data on Methamphetamine

Data on primary methamphetamine treatment admissions in the first half of 2009 reporting period were available and reported for 13 CEWG areas (table 10).¹² As a percentage of total treatment admissions, including primary alcohol admissions, Honolulu/Hawaii had the highest proportion of methamphetamine admissions, at 37.0 percent, followed by San Diego, at 29.7 percent, Phoenix, at 23.3 percent, and Los Angeles, at 18.7 percent. In the same period, primary methamphetamine

admissions accounted for approximately 10–14 percent of total primary admissions in San Francisco (10.3 percent), Denver (11.2 percent), and Colorado (14.0 percent). Only one CEWG area, New York City, reported that less than 1 percent of admissions were for primary methamphetamine abuse. On the other hand, five areas—Atlanta, Minneapolis/St. Paul, St. Louis, Seattle, and Texas—reported that between approximately 2 and 9 percent of primary treatment admissions were for methamphetamine abuse problems in this reporting period (table 10).

¹²Data for 10 areas, Baltimore, Boston, Chicago, Cincinnati, Detroit, Ft. Lauderdale, Maine, Maryland, Miami, and Philadelphia, were excluded due to small numbers (less than 30) (table 10).

Table 10. Primary Methamphetamine Treatment Admissions in 13 CEWG Areas¹ as a Percentage² of Total Admissions, Including and Excluding Primary Alcohol Admissions: 1H 2009^{3,4}

CEWG Areas ³	Primary Methamphetamine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁵		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	228	2,429	9.4	4,683	4.9
Colorado	2,022	8,414	24.0	14,457	14.0
Denver	678	3,762	18.0	6,040	11.2
Hawaii	2,119	3,895	54.4	5,730	37.0
Los Angeles	4,736	19,822	23.9	25,346	18.7
Minneapolis/St. Paul	592	4,834	12.2	10,315	5.7
New York City	104	29,092	0.4	40,713	0.3
Phoenix	505	1,377	36.7	2,166	23.3
St. Louis	141	3,710	3.8	5,771	2.4
San Diego	2,195	5,895	37.2	7,389	29.7
San Francisco	976	7,207	13.5	9,448	10.3
Seattle	707	4,631	15.3	7,533	9.4
Texas	3,815 ⁶	33,939	11.2	46,643	8.2

¹Data for 10 CEWG areas—Baltimore, Boston, Chicago, Cincinnati, Detroit, Ft. Lauderdale/Broward County, Maine, Maryland, Miami/Dade County, and Philadelphia—were excluded from this table due to small numbers (less than 30 total primary methamphetamine treatment admissions).

²Percentages are rounded to one decimal place.

³Data are for January–June 2009.

⁴More information on these data is available in the footnotes and notes for table 2 and appendix table 1.

⁵Percentages of primary methamphetamine admissions were obtained from admissions with primary alcohol admissions excluded for comparability with past data.

⁶Texas reported combined methamphetamine and amphetamine admissions.

SOURCE: January 2010 State and local CEWG reports

Based on rankings of primary drugs as a percentage of total treatment admissions, including primary alcohol admissions, methamphetamine ranked first in San Diego and Hawaii; second in Phoenix; third in Colorado, Denver, and Los Angeles; fourth in San Francisco and Hawaii; and fifth in Atlanta, Texas, and Seattle (section II, table 2).

Forensic Laboratory Data on Methamphetamine

In the first half of 2009, forensic laboratory data for CEWG reporting areas (figure 29; section II,

figure 21) show that methamphetamine was the drug identified most frequently in Honolulu (44.6 percent of total drug items). Items containing methamphetamine were next most frequently identified among total drug items in Minneapolis/St. Paul (27.5 percent), Atlanta (20.8 percent), Phoenix (20.2 percent), San Diego (19.3 percent), and San Francisco (19.2 percent) (figure 29). In nine of the CEWG reporting areas, less than 1 percent of the total drug items contained methamphetamine; all were in areas east of the Mississippi River (figure 29; appendix table 2).

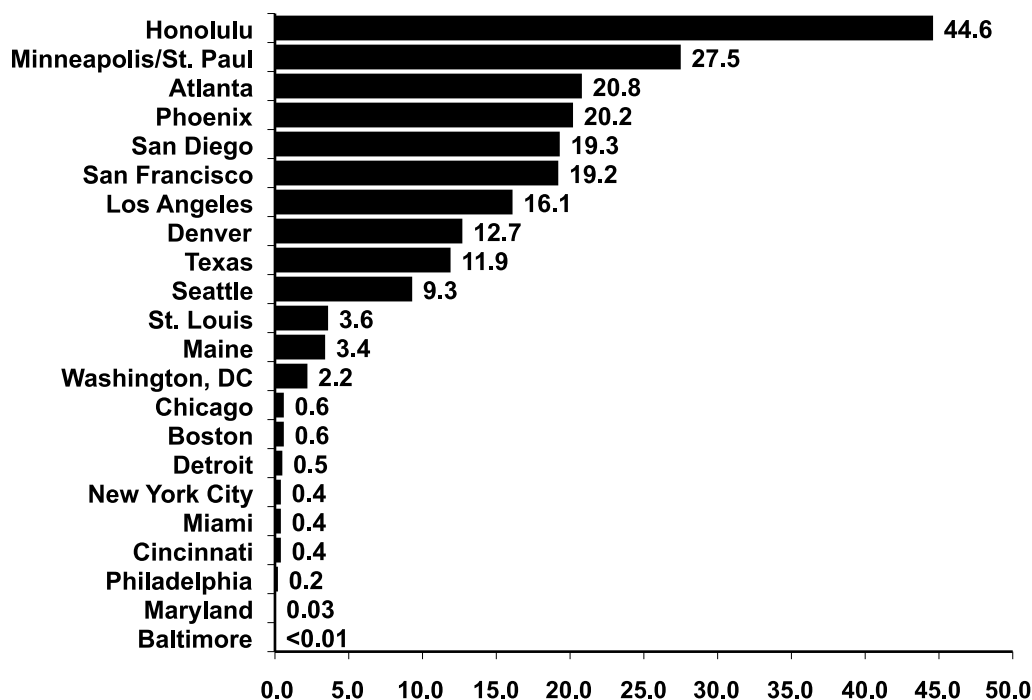
Methamphetamine ranked first in drug items identified in Honolulu; second in Atlanta, Minneapolis/St. Paul, Phoenix, and San Diego; and third in five CEWG areas—Denver, Los Angeles, San Francisco, Seattle, and Texas—in this reporting period (section II, table 1).

Weighted DAWN Estimates of ED Visits Involving Methamphetamine, 2004–2008

From 2004 to 2008, estimated numbers and rates of ED visits involving methamphetamine increased in 2 of 11 areas and decreased in 2 areas. Boston showed a 123-percent increase in ED visits involving methamphetamine in the period 2004–2008.

Boston rates increased from a very low base of 2.2 to 4.9 per 100,000 population over the period. A 10-percent increase in methamphetamine-involved ED visits was noted for San Diego, from 50.2 per 100,000 in 2004 to 54.1 in 2008. In Minneapolis/St. Paul in the period, methamphetamine-involved ED rates decreased by 42 percent, from 56.1 to 31.0 per 100,000 population, while San Francisco showed a 22-percent decline in such visits. San Francisco rates fell from 125.7 to 94.3 per 100,000 over the 5-year period. In the 1-year period between 2007 and 2008, Denver had decreases in estimated ED visit rates involving methamphetamine, which fell by 27 percent, from 49.6 to 35.5 per 100,000 (figure 30; appendix table 3.5).

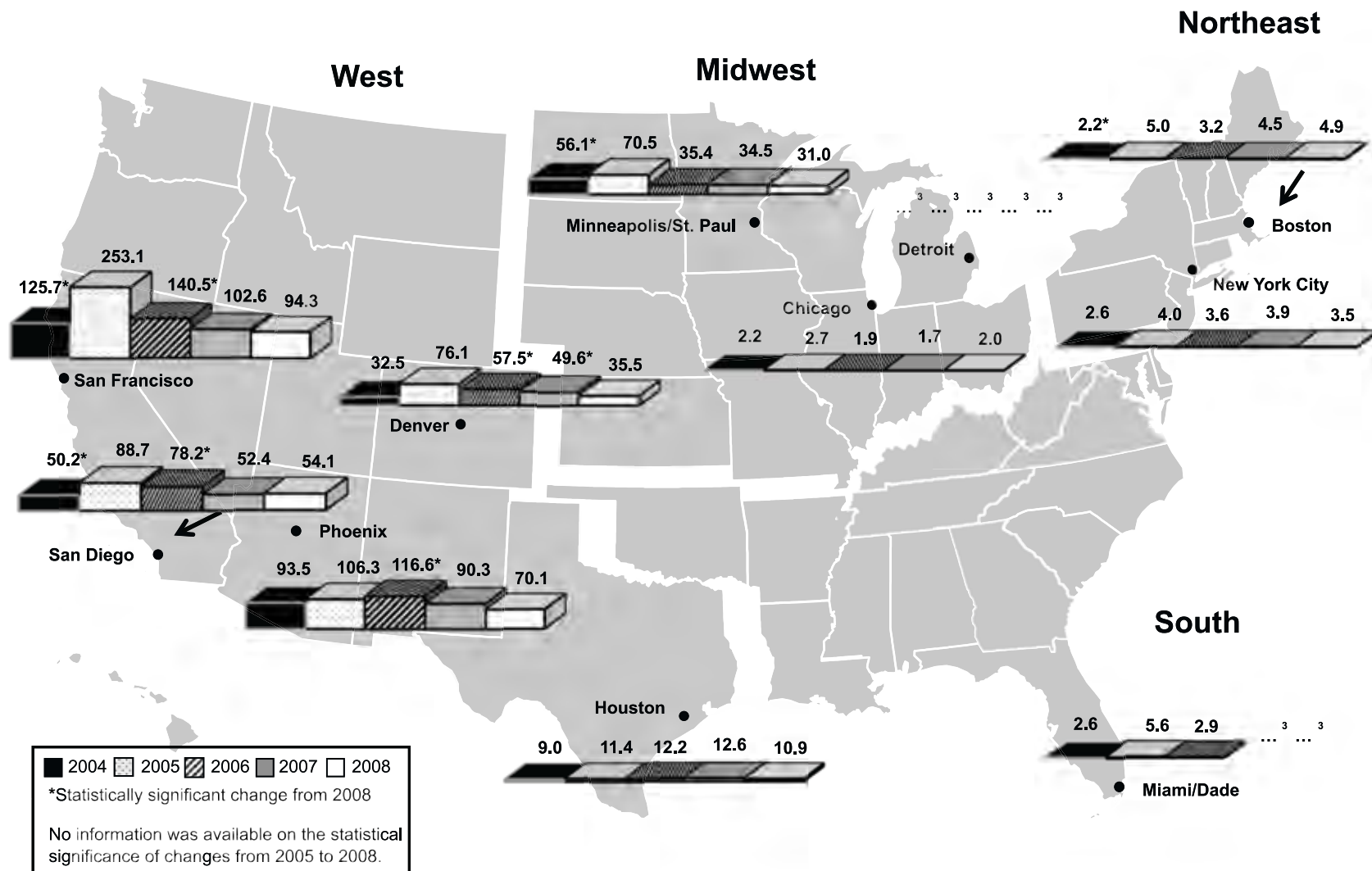
Figure 29. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2009¹



¹Data are for first half of 2009: January–June 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22

Figure 30. Weighted Estimates of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Methamphetamine¹ as Rates per 100,000 Population², for 11 CEWG Areas: 2004–2008



¹These are weighted estimates of methamphetamine-involved visits based on a representative sample of non-Federal, short-term hospitals with 24-hour emergency departments (EDs) in the United States.

²Rates per 100,000 population for methamphetamine are calculated based on total methamphetamine-involved visits including those for all case types; the population data are from the U.S. Census County-Level Population Estimates (CPOP) file.

³Three dots (...) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count less than 30 has been suppressed.

SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 4, 2009; data are subject to change (see appendix table 3.5)

Marijuana/Cannabis

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in the first half of 2009 in Ft. Lauderdale/Broward County (36.0 percent), followed by Miami/Dade County (32.4 percent), and Cincinnati (30.3 percent). The lowest proportions of such admissions were in Boston (4.7 percent) (table 28; appendix table 1).
- Marijuana ranked first as the primary drug problem in total drug admissions, including alcohol admissions, in 4 of 23 CEWG reporting areas; these were Ft. Lauderdale/Broward County, Miami/Dade County, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in nine additional areas: Atlanta, Cincinnati, Minneapolis/St. Paul, St. Louis, Denver, San Diego, Seattle, and the States of Colorado and Texas (section II, table 2).
- Cannabis/marijuana ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in the first half of 2009 in all CEWG areas, with the exception of Atlanta and Maine. Cannabis ranked in first place among identified drugs in 14 of 22 CEWG areas in this reporting period: Baltimore, Maryland, Boston, Philadelphia, Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, St. Louis, Los Angeles, Phoenix, San Diego, Seattle, and Texas. It ranked second in the remaining six areas (section II, table 1). The highest proportions of marijuana items identified in the NFLIS system were in Chicago, San Diego, and St. Louis, at approximately 58, 54, and 49 percent, respectively (figure 31; appendix table 2).
- Estimated DAWN ED visits involving marijuana increased in 5 of 11 reporting areas from 2004 to 2008. Respective increases in estimated marijuana-involved ED visits of 45, 224, 114, 174, and 147 percent were reported in Boston, Denver, Detroit, New York City, and San Diego. Increases were also observed in four areas from 2007 to 2008; these were Boston, Chicago, Houston, and San Francisco. They ranged from 5 percent in San Francisco to 59 percent in Houston (figure 32; appendix table 3.6).

Treatment Admissions Data on Marijuana

In the first half of 2009 reporting period, marijuana/cannabis ranked as the most frequently reported drug by primary treatment admissions in 4 of 23 CEWG areas, when primary alcohol admissions were included in the total (section II, table 2); these were Ft. Lauderdale/Broward County, Miami/Dade County, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in Atlanta, Cincinnati, Minneapolis/St. Paul, St. Louis, Denver, San Diego, and Seattle, and the States of Colorado and Texas (section II, table 2).

As shown in table 11, Ft. Lauderdale/Broward County had the highest percentage of primary marijuana treatment admissions, including primary

alcohol admissions, at 36.0 percent. In all, two other CEWG areas, besides Broward, had percentages of marijuana treatment admissions close to one-third: Miami/Dade County (32.4 percent) and Cincinnati (30.3 percent). The lowest proportion of marijuana treatment admissions was reported in Boston, at 4.7 percent.

Forensic Laboratory Data on Marijuana/Cannabis

Chicago had the highest percentage of marijuana identified by NFLIS laboratories in the first half of 2009 (58.0 percent), followed by San Diego and St. Louis (53.5 and 49.4 percent, respectively) (figure 31; appendix table 2). The proportions of cannabis drug items identified in the other 19 CEWG areas

Table 11. Primary Marijuana Treatment Admissions in 23 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: 1H 2009^{1,2}

CEWG Areas	Primary Marijuana Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	891	2,429	36.7	4,683	19.0
Baltimore	1,133	7,146	15.9	8,661	13.1
Boston	457	6,580	6.9	9,627	4.7
Chicago	4,535	19,415	23.4	25,197	18.0
Cincinnati	1,025	2,253	45.5	3,379	30.3
Colorado	3,220	8,414	38.3	14,457	22.3
Denver	1,477	3,762	39.3	6,040	24.5
Detroit	655	3,011	21.8	4,192	15.6
Ft. Lauderdale/Broward	833	1,720	48.4	2,313	36.0
Hawaii	1,281	3,895	32.9	5,730	22.4
Los Angeles	5,838	19,822	29.5	25,346	23.0
Maine	583	3,408	17.1	5,980	9.7
Maryland	5,901	21,348	27.6	32,301	18.3
Miami/Dade	671	1,589	42.2	2,069	32.4
Minneapolis/St. Paul	1,929	4,834	39.9	10,315	18.7
New York City	9,928	29,092	34.1	40,713	24.4
Philadelphia	2,089	6,098	34.3	7,969	26.2
Phoenix	321	1,377	23.3	2,166	14.8
St. Louis	1,243	3,710	33.5	5,771	21.5
San Diego	1,524	5,895	25.9	7,389	20.6
San Francisco	924	7,207	12.8	9,448	9.8
Seattle	1,437	4,631	31.0	7,533	19.1
Texas	11,396	33,939	33.6	46,643	24.4

¹More information on these data is available in the footnotes and notes for table 2 and appendix table 1.²Data are for January–June 2009.³Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

SOURCE: January 2010 State and local CEWG reports

were highest in Detroit (47.2 percent), Cincinnati (44.6 percent), Maryland (43.2 percent), and Seattle (42.9 percent). The remaining CEWG sites had percentages ranging from 3.0 percent in Atlanta¹³ to 38.0 percent in Los Angeles for cannabis drug items identified (figure 31).

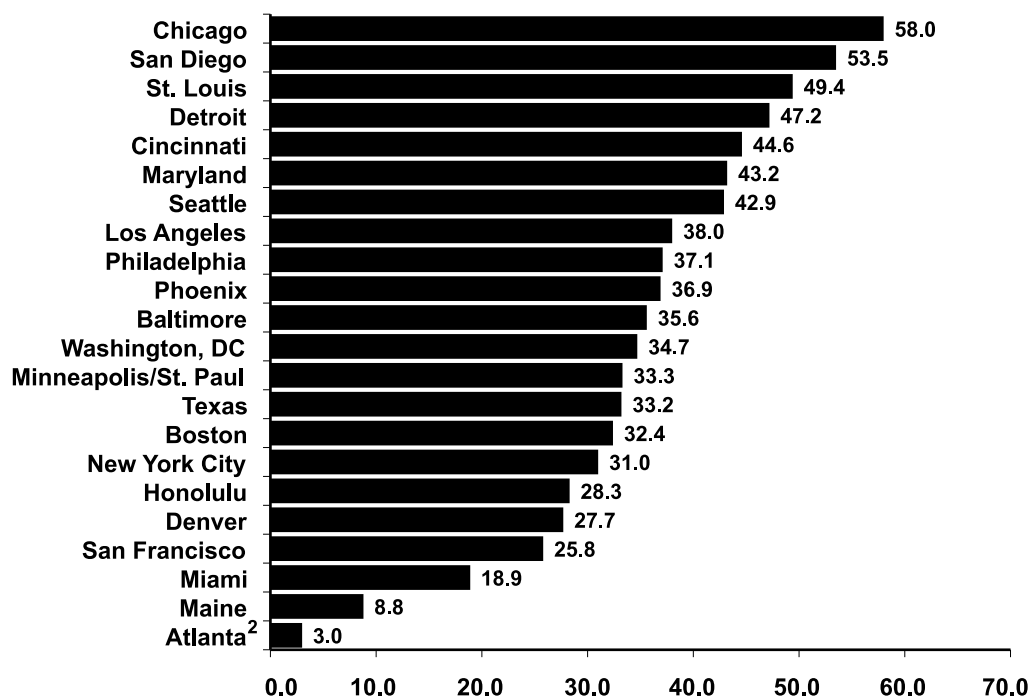
Cannabis ranked in either first or second place among drug items most frequently identified in all CEWG areas, with the exception of Atlanta, where it ranked sixth, and Maine, where it ranked third, in the first half of 2009. Cannabis ranked in first place among identified drugs in 14 of 22 CEWG areas in the period: Baltimore, Maryland, Boston, Philadelphia, Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, St. Louis, Los Angeles, Phoenix,

San Diego, Seattle, and Texas. It was the second most frequently identified drug item in the first half of 2009 NFLIS data in another six CEWG areas—Miami, Washington, DC, New York City, Denver, Honolulu, and San Francisco (section II, table 1).

Weighted DAWN Estimates of ED Visits Involving Marijuana, 2004–2008

From 2004 to 2008, estimated numbers and rates of ED visits involving marijuana increased in 5 of 11 CEWG areas for which weighted DAWN data were reported. Statistically significant increases in marijuana visits were reported for Boston, Denver, Detroit, New York City, and San Diego, with

Figure 31. Cannabis/THC Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2009¹



¹Data are for first half of 2009: January–June 2009.

²In 2004, Georgia initiated a statewide administrative policy that when cannabis is seized by law enforcement officers, laboratory testing is not required. This results in artificially low numbers of such drug items identified in the CEWG area relative to other CEWG areas.

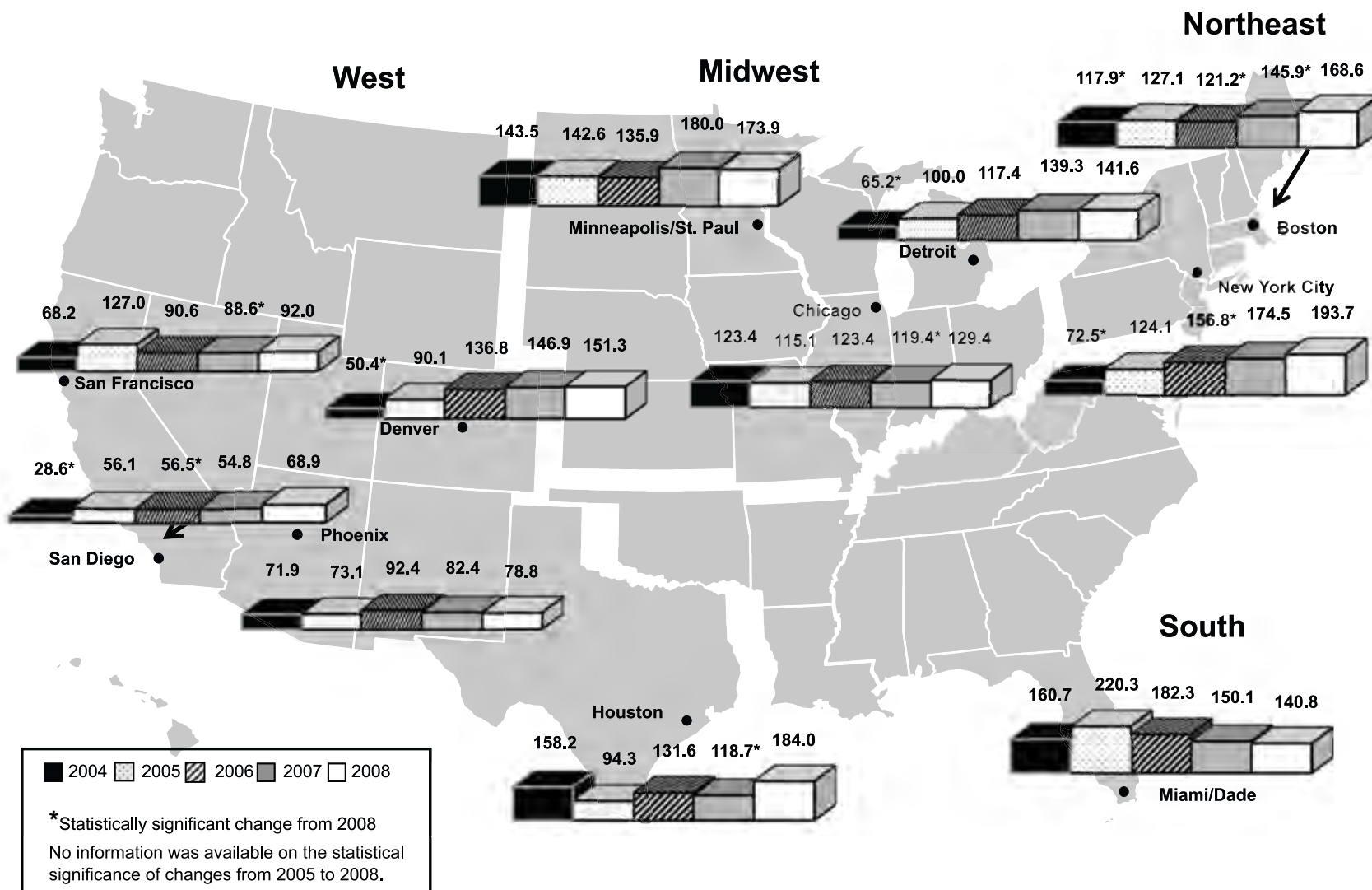
SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22

¹³In 2004, Georgia initiated a statewide administrative policy that laboratory testing is not required when cannabis is seized by law enforcement officers. This results in artificially low numbers of such drug items identified in this CEWG area relative to other CEWG areas.

respective increases of 45, 224, 114, 174, and 147 percent, from 2004 through 2008. Four areas—Boston, Chicago, Houston, and San Francisco—showed increases in estimated ED visits involving

marijuana of 16, 9, 59, and 5 percent, respectively, for the period 2007–2008 (figure 32; appendix table 3.6).

Figure 32. Weighted Estimates of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Marijuana¹ as Rates per 100,000 Population², for 11 CEWG Areas: 2004–2008



¹These are weighted estimates of marijuana-involved visits based on a representative sample of non-Federal, short-term hospitals with 24-hour emergency departments (EDs) in the United States.

²Rates per 100,000 population for marijuana are calculated based on total marijuana-involved visits including those for all case types; the population data are from the U.S. Census County-Level Population Estimates (CPOP) file.

SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 4, 2009; data are subject to change (see appendix table 3.6)

Club Drugs (MDMA, MDA, GHB/GBL, LSD, and Ketamine)

Treatment Admissions Data on Club Drugs

The club drugs reported on in this section include MDMA (or ecstasy), MDA, GHB, GBL, LSD, and ketamine. Admissions for primary treatment of club drugs or MDMA are not captured in all treatment data systems, but they appear low in those areas that do report on these drugs.

Forensic Laboratory Data on Club Drugs

MDMA. MDMA was the club drug most frequently reported among NFLIS data in the 22 CEWG areas depicted in table 12. As shown, MDMA equaled or exceeded 2 percent of all drug items in six areas. These include San Francisco, Maine, and Minneapolis/St. Paul, which had the highest percentages (4.2, 3.8, and 3.7 percent, respectively), followed by Denver (2.9 percent), Los Angeles (2.8 percent), and Atlanta (2.6 percent). As shown in section II, table 1, MDMA was the fourth most frequently identified drug item in Chicago, Minneapolis, and Honolulu in the first half of 2009. It ranked fifth in 6 of 22 reporting areas: Maine, Detroit, Denver, Los Angeles, San Diego, and San Francisco (section II, table 1).

MDA. MDA was reported among drug items identified in 8 of 22 areas: Atlanta, Baltimore, Denver, Honolulu, New York City, Philadelphia, Phoenix, and San Francisco (table 13). However, it was not reported in the top 10 most frequently

identified drug items in any CEWG area in the first half of 2009 (section II, table 1).

GHB. GHB drug items were not among the top 10 drug items identified for any CEWG area in the first half of 2009, although 6 of 22 areas reported 1 or more such drug items, including Atlanta, Chicago, New York City, San Diego, San Francisco, and Texas. In Texas, drug items identified as containing GHB represented 53 cases, but they were negligible in other areas (table 13).

LSD. LSD was not among the top 10 drugs reported in the NFLIS system for any CEWG reporting area (section II, table 1), but it appeared as 1 of the drug items identified in forensic laboratory data in 12 of 22 CEWG reporting areas: Atlanta, Boston, Chicago, Denver, Los Angeles, Maine, Miami, New York City, Phoenix, San Francisco, Seattle, and Texas. Numbers of such drug items ranged from 1 to 27 (table 13).

Ketamine. Ketamine was among the drug items identified in the NFLIS system in the first half of 2009 in 16 of 22 areas, with exceptions being Cincinnati, Honolulu, Minneapolis/St. Paul, St. Louis, Seattle, and Washington, DC. (table 13). Two areas reported identification of 30 or more ketamine-containing drug items: New York City ($n=120$) and Texas ($n=66$) (table 13). Ketamine did not figure among the top 10 most frequently identified drug items in any CEWG area (section II, table 1).

Table 12. Number of MDMA Items Identified and MDMA Items as a Percentage of Total Items Identified by Forensic Laboratories in 22 CEWG Areas: 1H 2009¹

CEWG Area	MDMA Items	Total Items Identified	Percentage of Total Items Identified
Atlanta	156	5,908	2.6
Baltimore	55	20,230	0.3
Boston	54	6,753	0.8
Chicago	743	42,018	1.8
Cincinnati	65	5,956	1.1
Denver	119	4,084	2.9
Detroit	94	4,870	1.9
Honolulu	11	735	1.5
Los Angeles	685	24,141	2.8
Maine	17	443	3.8
Maryland	86	29,245	0.3
Miami	163	13,106	1.2
Minneapolis/ St. Paul	75	2,020	3.7
New York City	404	29,147	1.4
Philadelphia	31	18,408	0.2
Phoenix	44	2,913	1.5
St. Louis	127	9,953	1.3
San Diego	206	11,120	1.9
San Francisco	398	9,424	4.2
Seattle	14	1,458	1.0
Texas	1,038	55,247	1.9
Washington, DC	9	1,643	0.5

¹Data are for January–June 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

Table 13. Numbers of MDA, GHB, Ketamine, LSD, PCP, and Other Drug Items¹ Identified by Forensic Laboratories in 22 CEWG Areas: 1H 2009²

CEWG AREAS	MDA	GHB	PCP	LSD	Psilocin ³	Ketamine	BZP	Cariso-prodol	Total, All Drug Items
Atlanta	7	1	--	5	16	7	26	53	5,908
Baltimore	1	--	2	--	3	1	38	--	20,230
Boston	--	--	--	10	18	5	27	8	6,753
Chicago	--	5	119	9	69	11	610	4	42,018
Cincinnati	--	--	--	--	7	--	4	--	5,956
Denver	15	--	--	3	44	2	75	2	4,084
Detroit	--	--	--	--	6	2	50	1	4,870
Honolulu	2	--	--	--	--	--	6	2	735
Los Angeles	--	--	214	9	82	22	129	78	24,141
Maine	--	--	1	2	--	1	7	--	443
Maryland	--	--	72	--	17	3	70	--	29,245
Miami	--	--	-- ⁴	3	4	18	87	11	13,106
Minneapolis/ St. Paul	--	--	--	--	25	--	7	2	2,020
New York City	22	4	244	2	7	120	101	--	29,147
Philadelphia	3	--	508	--	6	2	32	--	18,408
Phoenix	1	--	6	1	18	2	4	30	2,913
St. Louis	--	--	10	--	27	--	217	6	9,953
San Diego	--	3	24	--	41	8	33	7	11,120
San Francisco	5	6	7	7	48	18	2	2	9,424
Seattle	--	--	15	2	3	--	38	--	1,458
Texas	--	53	166	27	117	66	810	529	55,247
Washington, DC	--	--	92	--	--	--	14	--	1,643

¹TFMPP was found in 81 drug items identified in Atlanta; 74 in Texas; 29 in Chicago; 16 in Washington, DC; 3 in New York City; 2 each in St. Louis and San Francisco; and 1 in Denver in the first half of 2009. Drug items containing Foxy Methoxy were identified in one area only: San Francisco ($n=2$).

²Data are for January–June 2009.

³Psilocybine, psilocybin, psylocin, and psilocin are grouped together in this table under the category "Psilocin".

⁴Miami does not report PCP as a separate category, reporting 216 "hallucinogens" identified in the first half of 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia received December 10, 2009; Philadelphia data received January 28, 2010; see appendix tables 2.1–2.22; data are subject to change and may differ according to the date on which the data were queried

Phencyclidine (PCP)

Forensic Laboratory Data on PCP

PCP figured among the top 10 most frequently identified drug items in forensic laboratories in six CEWG areas from NFLIS data for the first half of 2009. In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in the current reporting period. PCP was also among the top drug items identified in Philadelphia and Los Angeles, where it ranked sixth and seventh, respectively. In the first half of 2009, PCP ranked eighth in New York City and ninth in Chicago and Seattle (section II, table 1).

No PCP items were identified in forensic laboratory data in eight CEWG areas: Atlanta, Boston,

Cincinnati, Denver, Detroit, Honolulu, Miami, and Minneapolis/St. Paul (table 13; section II, table 1; appendix table 2). Fewer than 30 such items were identified in seven areas (Baltimore, Maine, Phoenix, St. Louis, San Diego, San Francisco, and Seattle). The areas reporting 30 or more PCP items were Chicago, Los Angeles, Maryland, New York City, Philadelphia, Texas, and Washington, DC. The range in these areas was from 72 in Maryland to 508 in Philadelphia (table 13). As a percentage of all identified items, PCP items were highest in Washington, DC, at 5.6 percent, followed by Philadelphia, at 2.8 percent.

Other Drugs, Including BZP, TFMPP, Foxy Methoxy, Psilocin, and Carisoprodol

BZP. In the first half of 2009, BZP emerged among the identified drugs in NFLIS forensic laboratories in all 22 CEWG areas, compared with 18 of 22 areas in CY 2008 (table 13). This contrasts with 2007, when none of the 22 CEWG areas, with the exception of Detroit, listed BZP-containing drug items among the drugs identified in forensic laboratories. In Detroit, for example, 11 BZP items were identified in 2007, representing 0.1 percent of all drug items identified, while in 2008, 32 items, or 0.5 percent of drug items in the period, were so identified. The number had jumped to 50, or 1.0 percent, for the first half of 2009. Section II, table 1 shows BZP rankings among the top 10 most frequently identified drug items in NFLIS data in the first half of 2009 in 12 of 22 CEWG areas. BZP ranked 5th in Chicago and St. Louis; 6th in Honolulu and Seattle; 7th in Detroit and Denver; 8th in Miami, Washington, DC, and Texas; 9th in Los Angeles; and 10th in Baltimore and Maine.

TFMPP. The identification of this drug in NFLIS data for the first half of 2009 was localized in NFLIS reporting to eight areas—Atlanta ($n=81$), Texas ($n=74$), Chicago ($n=29$), Washington, DC ($n=16$), New York City ($n=3$), St. Louis and San Francisco ($n=2$ each), and Denver ($n=1$) (table 13, footnote 1). In the first half of 2009 forensic laboratory data, TFMPP ranked seventh in frequency among drug items identified in Washington, DC, and ninth in Atlanta (section II, table 1).

Foxy or Foxy Methoxy. Foxy Methoxy drug items were identified in forensic laboratories in one CEWG area, San Francisco, where two such drug items were reported in the NFLIS system in the first half of 2009 (table 13, footnote 1).

Psilocin. The hallucinogen psilocin (also called psilocin/psilocybin and psilocybine) ranked 8th in Minneapolis/St. Paul, 9th in Denver, and 10th in Phoenix in the NFLIS data for the current reporting period (section II, table 1). Psilocin/psilocybin was reported among drug items in forensic laboratories in 19 of 22 CEWG areas, with a range of 3 (Baltimore) to 117 (Texas), in the first half of 2009 (table 13).

Carisoprodol. Carisoprodol was identified in 14 of 22 reporting areas in the first half of 2009, compared with 6 areas in 2008. The former areas were: Atlanta, Boston, Chicago, Denver, Detroit, Honolulu, Los Angeles, Miami, Minneapolis/St. Paul, Phoenix, St. Louis, San Diego, San Francisco, and Texas. Carisoprodol drug items identified ranged in these areas from 1 to 529 cases in Detroit and Texas, respectively (table 13). In the first half of 2009, drug items containing carisoprodol ranked ninth in Texas and Phoenix among the 10 most frequently identified items from CEWG areas (section II, table 1).

Appendix Tables

Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: 1H 2009¹

CEWG Areas	Number of Total Admissions							Total (N) ³
	Alcohol	Cocaine/ Crack ²	Heroin	Other Opiates	Meth- amphet- amine	Marijuana	Other Drugs/ Unknown	
Atlanta	2,254 ⁴	754	181	230	228	891	145	4,683
Baltimore	1,515	1,210	4,414	297	5	1,133	87	8,661
Boston	3,047	694	4,822	448	22	457	137	9,627
Chicago	5,782	4,759	9,596	128	22	4,535	375	25,197
Cincinnati	1,126	466	524 ⁵	--	10 ⁶	1,025	228	3,379
Colorado	6,043	1,358	793	731	2,022	3,220	290	14,457
Denver	2,278	661	485	294	678	1,477	167	6,040
Detroit	1,181	776	1,461	106	1	655	12	4,192
Ft. Lauderdale/Broward	593	331	47	144	10	833	355	2,313
Hawaii	1,835	177	107	NR ⁷	2,119	1,281	211	5,730
Los Angeles	5,524	3,590	4,517	573	4,736	5,838	568	25,346
Maine	2,572	270	555	1,896	16	583	88	5,980
Maryland	10,953	3,604	8,131	2,946	28	5,901	738	32,301
Miami/Dade County	480	667	64	40	10	671	137	2,069
Minneapolis/ St. Paul	5,481	665	672	771	592	1,929	205	10,315
New York City	11,621 ⁴	6,932	10,618	578	104	9,928	932	40,713
Philadelphia	1,871	1,725	1,159	180	4	2,089	941	7,969
Phoenix	789	139	300	77	505	321	35	2,166 ⁸
St. Louis	2,061	825	1,240	157	141	1,243	104	5,771
San Diego	1,494	408	1,367	290	2,195	1,524	111	7,389
San Francisco	2,241	2,048	3,189 ⁵	----	976	924	70	9,448
Seattle	2,902	1,001	839	356	707	1,437	291	7,533
Texas	12,704	8,577	5,727	2,862	3,815 ⁶	11,396	1,562	46,643

¹Data are for January–June 2009.

²Cocaine values were broken down into crack or powder/other cocaine for the following areas: Atlanta (crack=495; powder or other cocaine=259); Baltimore (crack=1,061; powder or other cocaine=149); Boston (crack=411; powder or other cocaine=283); Detroit (crack=711; powder or other cocaine=65); Ft. Lauderdale/Broward County (crack=265; powder or other cocaine=66); Maine (crack=87; powder or other cocaine=183); Maryland (crack=2,914; powder or other cocaine=690); Miami/Dade County (crack=358; powder or other cocaine=309); Minneapolis/St. Paul (crack=516; powder or other cocaine=149); New York City (crack=4,235; powder or other cocaine=2,697); St. Louis (crack=736; powder or other cocaine=89); and Texas (crack=4,963; powder or other cocaine=3,614). No breakdowns by type of cocaine were available for Chicago, Cincinnati, Colorado, Denver, Hawaii, Los Angeles, Philadelphia, Phoenix, San Diego, San Francisco, and Seattle.

³These *N*'s are used in all percentage calculations involving total treatment admissions data for each area. Treatment data contain unknown primary admissions in Atlanta (*n*=3), Chicago (*n*=153), Ft. Lauderdale/Broward County (*n*=249), Miami/Dade County (*n*=87), Minneapolis/St. Paul (*n*=60), and New York City (*n*=301). Since these cases may be classified as to route of administration and demographic characteristics, they are included in the numbers for these areas and are included with "Other Drugs/Unknown" in this table. Total admissions data for all other areas exclude unknowns.

⁴Alcohol data for Atlanta are alcohol only=991, and alcohol in combination with other drugs=1,263; alcohol data for New York City are alcohol only=5,143, and alcohol in combination with other drugs=6,478.

⁵Heroin and other opiates are grouped together for Cincinnati and San Francisco; data are included in primary heroin treatment admissions counts and tables only.

⁶Methamphetamine, amphetamine, and MDMA are grouped together for Cincinnati; methamphetamine and amphetamine are grouped together for Texas.

⁷NR=Not reported by the CEWG area representative.

⁸Phoenix data report total admissions of 3,996, of which 1,830 did not report using any drugs at admission for substance abuse treatment; the *N* of 2,166 includes only cases in which a primary drug was reported. Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: January 2010 State and local CEWG reports

Appendix Tables 2.1–2.22. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 22 CEWG Areas: January–June 2009

Appendix 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: 1H 2009¹

Drug	Number	Percentage
Cocaine	2,918	49.4
Methamphetamine	1,227	20.8
Alprazolam	267	4.5
Hydrocodone	241	4.1
Oxycodone	230	3.9
Cannabis/THC	177	3.0
3,4-Methylenedioxy-methamphetamine	156	2.6
Heroin	130	2.2
1-(3-Trifluoromethyl-phenyl)piperazine	81	1.4
Amphetamine	63	1.1
Other ²	418	7.1
Total	5,908	100.0

¹January 2009–June 2009.

²All other analyzed items.

NOTES:

1. Data are for the 28-county Atlanta/Sandy Springs/Marietta GA MSA: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	2,189	32.4
Cocaine	1,648	24.4
Heroin	931	13.8
Oxycodone	437	6.5
Buprenorphine	167	2.5
Clonazepam	146	2.2
Alprazolam	97	1.4
Hydrocodone	59	0.9
3,4-Methylenedioxy-methamphetamine	54	0.8
Methadone	41	0.6
Other ²	984	14.6
Total	6,753	100.0

¹January 2009–June 2009.

²All other analyzed items. "Noncontrolled Nonnarcotic Drug" represents 111 cases and is included under "Other." "No Drug Found" represents 171 cases and is included under "Other."

NOTES:

1. Data are for all counties in the Boston MSA: Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Baltimore City: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	7,196	35.6
Cocaine	6,928	34.2
Heroin	5,146	25.4
Buprenorphine	274	1.4
Oxycodone	135	0.7
Alprazolam	103	0.5
Clonazepam	67	0.3
3,4-Methylenedioxy-methamphetamine	55	0.3
Methadone	48	0.2
1-Benzylpiperazine	38	0.2
Other ²	240	1.2
Total	20,230	100.0

¹January 2009–June 2009.

²All other analyzed items.

NOTES:

1. Data are for Baltimore City only

2. Percentages may not sum to the total due to rounding

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	24,374	58.0
Cocaine	9,345	22.2
Heroin	5,300	12.6
3,4-Methylenedioxy-methamphetamine	743	1.8
1-Benzylpiperazine	610	1.5
Hydrocodone	269	0.6
Methamphetamine	269	0.6
Alprazolam	162	0.4
Phencyclidine	119	0.3
Acetaminophen	94	0.2
Other ²	733	1.7
Total	42,018	100.0

¹January 2009–June 2009.

²All other analyzed items.

NOTES:

1. Data are for 13 counties in the Chicago/Naperville/Joliet, IL/IN/WI MSA: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter Counties in IN; and Kenosha County in WI.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	2,657	44.6
Cocaine	2,174	36.5
Heroin	574	9.6
Oxycodone	124	2.1
Hydrocodone	75	1.3
3,4-Methylenedioxy-methamphetamine	65	1.1
Alprazolam	54	0.9
Diazepam	39	0.7
Methadone	24	0.4
Clonazepam ²	21	0.4
Methamphetamine	21	0.4
Other ³	128	2.1
Total	5,956	100.0

¹January 2009–June 2009.

²Clonazepam and Methamphetamine were tied for 10th most frequently identified drug.

³All other analyzed items.

NOTES:

1. Data are for Hamilton County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	2,300	47.2
Cocaine	1,286	26.4
Heroin	525	10.8
Hydrocodone	206	4.2
3,4-Methylenedioxy-methamphetamine	94	1.9
Alprazolam	73	1.5
1-Benzylpiperazine	50	1.0
Oxycodone	36	0.7
Methamphetamine	25	0.5
Codeine ²	13	0.3
Diazepam	13	0.3
Other ³	249	5.1
Total	4,870	100.0

¹January 2009–June 2009.

²Codeine and Diazepam were tied for 10th most frequently identified drugs.

³All other analyzed items. "Noncontrolled Nonnarcotic Drug" represents 161 cases and is included under "Other."

NOTES:

1. Data are for Wayne County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: 1H 2009¹

Drug	Number	Percentage
Cocaine	1,384	33.9
Cannabis/THC	1,131	27.7
Methamphetamine	518	12.7
Heroin	237	5.8
3,4-Methylenedioxy-methamphetamine	119	2.9
Oxycodone	77	1.9
1-Benzylpiperazine	75	1.8
Hydrocodone	53	1.3
Psilocin	40	1.0
Alprazolam	24	0.6
Other ²	426	10.4
Total	4,084	100.0

¹January 2009–June 2009.

²All other analyzed items. "Noncontrolled Nonnarcotic Drug" represents 236 cases and is included under "Other."

NOTES:

1. Data are for Denver, Arapahoe, and Jefferson Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: 1H 2009¹

Drug	Number	Percentage
Methamphetamine	328	44.6
Cannabis/THC	208	28.3
Cocaine	135	18.4
3,4-Methylenedioxy-methamphetamine	11	1.5
Heroin	8	1.1
1-Benzylpiperazine	6	0.8
Acetaminophen	6	0.8
Alprazolam	5	0.7
Methadone ²	4	0.5
Morphine	4	0.5
Other ³	20	2.7
Total	735	100.0

¹January 2009–June 2009.

²Methadone and Morphine were tied for 10th most frequently identified drug.

³All other analyzed items.

NOTES:

1. Data are for Honolulu County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	9,163	38.0
Cocaine	6,670	27.6
Methamphetamine	3,892	16.1
Heroin	1,212	5.0
3,4-Methylenedioxy-methamphetamine	685	2.8
Hydrocodone	391	1.6
Phencyclidine	214	0.9
Alprazolam	175	0.7
1-Benzylpiperazine	129	0.5
Oxycodone	98	0.4
Other ²	1,512	6.3
Total	24,141	100.0

¹January 2009–June 2009.

²All other analyzed items. "No Drug Found" represents 259 cases and is included under "Other." "Noncontrolled Nonnarcotic Drug" represents 134 cases and is included under "Other."

NOTES:

1. Data are for Los Angeles County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maine: 1H 2009¹

Drug	Number	Percentage
Cocaine	185	41.8
Heroin	67	15.1
Cannabis/THC	39	8.8
Oxycodone	38	8.6
3,4-Methylenedioxy-methamphetamine	17	3.8
Methamphetamine	15	3.4
Buprenorphine	11	2.5
Hydrocodone	11	2.5
Methadone	9	2.0
1-Benzylpiperazine ²	7	1.6
Morphine	7	1.6
Other ³	37	8.4
Total	443	100.0

¹January 2009–June 2009.

²1-Benzylpiperazine and Morphine were tied for the 10th most frequently identified drug.

³All other analyzed items.

NOTES:

1. Data are for the State of Maine.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maryland: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	12,619	43.2
Cocaine	8,813	30.1
Heroin	5,730	19.6
Oxycodone	446	1.5
Buprenorphine	368	1.3
Alprazolam	219	0.8
Clonazepam	121	0.4
3,4-Methylenedioxy-methamphetamine	86	0.3
Methadone	83	0.3
Hydrocodone	83	0.3
Other ²	677	2.3
Total	29,245	100.0

¹January 2009–June 2009.

²All other analyzed items. "No Drug Found" represents 85 cases and is included under "Other."

NOTES:

1. Data are for the State of Maryland.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami: 1H 2009¹

Drug	Number	Percentage
Cocaine	8,073	61.6
Cannabis/THC	2,477	18.9
Heroin	369	2.8
Alprazolam	284	2.2
Hallucinogen (Nonspecified)	216	1.6
3,4-Methylenedioxy-methamphetamine	163	1.2
Oxycodone	148	1.1
1-Benzylpiperazine	87	0.7
Methamphetamine	47	0.4
Hydrocodone	37	0.3
Other ²	1,205	9.2
Total	13,106	100.0

¹January 2009–June 2009.

²All other analyzed items. "Controlled Substance Nonspecified" represents 706 cases and is included under "Other." "No Drug Found" represents 292 cases and is included under "Other."

NOTES:

1. Data are for the Miami/Fort Lauderdale/Pompano Beach MSA and include Broward, Dade, and Palm Beach Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/St. Paul: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	673	33.3
Methamphetamine	555	27.5
Cocaine	409	20.2
3,4-Methylenedioxy-methamphetamine	75	3.7
Heroin	46	2.3
Oxycodone	39	1.9
Amphetamine	18	0.9
Psilocybin/Psilocyn	17	0.8
Hydrocodone	16	0.8
Acetaminophen	13	0.6
Other ²	159	7.9
Total	2,020	100.0

¹January 2009–June 2009.

²All other analyzed items.

NOTES:

1. Data are for seven counties in Minnesota in the 13-county Minneapolis/St. Paul/ Bloomington MN/WI MSA: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: 1H 2009¹

Drug	Number	Percentage
Cocaine	11,340	38.9
Cannabis/THC	9,039	31.0
Heroin	3,182	10.9
Alprazolam	762	2.6
Oxycodone	520	1.8
3,4-Methylenedioxy-methamphetamine	404	1.4
Methadone	327	1.1
Phencyclidine	244	0.8
Hydrocodone	214	0.7
Clonazepam	185	0.6
Other ²	2,930	10.1
Total	29,147	100.0

¹January 2009–June 2009.

²All other analyzed items. "No Drug Found" represents 1,836 cases and is included under "Other."

NOTES:

1. Data are for the New York City Police Department and five NY counties: Bronx, Kings, Queens, New York, and Richmond Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	6,838	37.1
Cocaine	6,246	33.9
Heroin	2,194	11.9
Oxycodone	732	4.0
Alprazolam	657	3.6
Phencyclidine	508	2.8
Codeine	143	0.8
Clonazepam	108	0.6
Hydrocodone	98	0.5
Diazepam	63	0.3
Other ²	821	4.5
Total	18,408	100.0

¹January 2009–June 2009.

²All other analyzed items. "Noncontrolled Nonnarcotic Drug" represents 509 cases and is included under "Other."

NOTES:

1. Data are for Philadelphia County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 28, 2010; data are subject to change

Appendix 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	1,076	36.9
Methamphetamine	588	20.2
Cocaine	542	18.6
Heroin	296	10.2
Oxycodone	90	3.1
3,4-Methylenedioxy-methamphetamine	44	1.5
Hydrocodone	42	1.4
Alprazolam	32	1.1
Carisoprodol	30	1.0
Clonazepam ²	18	0.6
Psilocin	18	0.6
Other ³	137	4.7
Total	2,913	100.0

¹January 2009–June 2009.

²Clonazepam and Psilocin were tied for 10th most frequently identified drug.

³All other analyzed items. "No Drug Found" represents 20 cases and is included under "Other."

NOTES:

1. Data are for Maricopa County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	4,920	49.4
Cocaine	1,498	15.1
Heroin	1,048	10.5
Methamphetamine	360	3.6
1-Benzylpiperazine	217	2.2
Hydrocodone	214	2.2
Alprazolam	191	1.9
Oxycodone	147	1.5
Pseudoephedrine	128	1.3
3,4-Methylenedioxy-methamphetamine	127	1.3
Other ²	1,103	11.1
Total	9,953	100.0

¹January 2009–June 2009.

²All other analyzed items. "No Drug Found" represents 468 cases and is included under "Other."

NOTES:

1. Data are for the St. Louis MO/IL MSA, which includes the City of St. Louis and 16 counties: St. Louis, St. Charles, Crawford, Jefferson, Franklin, Lincoln, Warren, and Washington Counties in Missouri; and Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, St. Clair, and Calhoun Counties in Illinois.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: 1H 2009¹

Drug	Number	Percentage
Cocaine	2,445	25.9
Cannabis/THC	2,431	25.8
Methamphetamine	1,807	19.2
Heroin	452	4.8
3,4-Methylenedioxy-methamphetamine	398	4.2
Oxycodone	297	3.2
Hydrocodone	248	2.6
Methadone	122	1.3
Morphine	111	1.2
Clonazepam	94	1.0
Other ²	1,019	10.8
Total	9,424	100.0

¹January 2009–June 2009.

²All other analyzed items. "No Drug Found" represents 562 cases and is included under "Other."

NOTES:

1. Data are for the five counties in the San Francisco/Oakland/Fremont MSA: Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	5,949	53.5
Methamphetamine	2,142	19.3
Cocaine	1,084	9.7
Heroin	371	3.3
3,4-Methylenedioxy-methamphetamine	206	1.9
Hydrocodone	204	1.8
Oxycodone	148	1.3
Alprazolam	105	0.9
Clonazepam	63	0.6
Diazepam ²	56	0.5
Morphine	56	0.5
Other ³	736	6.6
Total	11,120	100.0

¹January 2009–June 2009.

²Diazepam and Morphine were tied for 10th most frequently identified drug.

³All other analyzed items. "Plant Material, Other" represents 181 cases and is included under "Other."

NOTES:

1. Data are for San Diego County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	625	42.9
Cocaine	330	22.6
Methamphetamine	136	9.3
Heroin	107	7.3
Oxycodone	81	5.6
1-Benzylpiperazine	38	2.6
Buprenorphine	17	1.2
Hydrocodone	17	1.2
Phencyclidine	15	1.0
3,4-Methylenedioxy-methamphetamine ²	14	1.0
Cathinone	14	1.0
Other ³	64	4.4
Total	1,458	100.0

¹January 2009–June 2009.

²3,4-Methylenedioxymethamphetamine and Cathinone were tied for the 10th most frequently identified drug.

³All other analyzed items.

NOTES:

1. Data are for King County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: 1H 2009¹

Drug	Number	Percentage
Cannabis/THC	18,324	33.2
Cocaine	16,112	29.2
Methamphetamine	6,574	11.9
Alprazolam	2,360	4.3
Hydrocodone	1,952	3.5
Heroin	1,565	2.8
3,4-Methylenedioxy-methamphetamine	1,038	1.9
1-Benzylpiperazine	810	1.5
Carisoprodol	529	1.0
Clonazepam	476	0.9
Other ²	5,507	10.0
Total	55,247	100.0

¹January 2009–June 2009.²All other analyzed items. "No Drug Found" represents 867 cases and is included under "Other."

NOTES:

1. Data are for the State of Texas.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: 1H 2009¹

Drug	Number	Percentage
Cocaine	652	39.7
Cannabis/THC	570	34.7
Heroin	166	10.1
Phencyclidine	92	5.6
Methamphetamine	36	2.2
Oxycodone	21	1.3
1-(3-Trifluoromethyl-phenyl)piperazine	16	1.0
1-Benzylpiperazine	14	0.9
Buprenorphine	14	0.9
6-Monoacetylmorphine	13	0.8
Other ²	49	3.0
Total	1,643	100.0

¹January 2009–June 2009.²All other analyzed items.

NOTES:

1. Data are for the District of Columbia.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, December 10, 2009; data are subject to change

Appendix Table 3.1. Weighted Estimates¹ of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Cocaine², and Rates per 100,000 Population for 11 CEWG Areas: 2004–2008

CEWG Areas	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2008	Percent and Direction of Change, 2004–2008 ³ (%)	Percent and Direction of Change, 2006–2008 ³ (%)	Percent and Direction of Change, 2007–2008 ³ (%)
Boston	9,408 (211.2)	11,175 (250.9)	11,295 (252.8)	13,582 (302.3)	12,788 (282.8)	+36	--	-6
Chicago	31,113 (332.7)	30,224 (321.9)	34,857 (369.3)	31,188 (328.4)	30,667 (320.5)	--	-12	--
Denver	2,164 (93.1)	4,079 (173.0)	4,942 (205.6)	5,027 (204.9)	4,212 (168.1)	+95	-15	-16
Detroit	5,221 (116.1)	9,860 (219.3)	12,676 (282.5)	12,631 (283.4)	10,021 (226.5)	+92	-21	-21
Houston	10,850 (208.9)	6,691 (126.2)	9,925 (180.9)	10,884 (194.4)	16,269 (284.0)	--	+64	--
Miami/Dade	9,469 (405.1)	13,061 (554.2)	9,944 (418.4)	9,827 (412.4)	7,498 (312.6)	--	--	--
Minneapolis/St. Paul	6,228 (200.5)	6,076 (194.0)	6,764 (213.8)	5,189 (162.3)	5,390 (166.9)	--	--	--
New York City	20,445 (250.2)	30,478 (371.1)	36,791 (445.9)	35,706 (429.7)	31,647 (378.4)	+55	-14	-11
Phoenix	3,717 (100.0)	3,607 (93.1)	5,804 (143.8)	5,065 (121.6)	3,933 (91.9)	--	-32	-22
San Diego	808 (27.6)	1,224 (41.7)	1,355 (46.1)	1,188 (40.2)	1,422 (47.4)	--	--	--
San Francisco	4,419 (258.4)	6,944 (404.7)	5,773 (334.0)	6,055 (346.4)	4,160 (235.0)	--	-28	--

¹Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

²It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.

³This column denotes statistically significant ($p < .05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol "--" indicates no statistically significant changes in the estimates between the reporting periods shown.

SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/04/2009

Appendix Table 3.2. Weighted Estimates¹ of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Heroin², and Rates per 100,000 Population for 11 CEWG Areas: 2004–2008

CEWG Areas	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2008	Percent and Direction of Change, 2004–2008 ³ (%)	Percent and Direction of Change, 2006–2008 ³ (%)	Percent and Direction of Change, 2007–2008 ³ (%)
Boston	10,295 (231.1)	8,667 (194.5)	9,413 (210.7)	11,003 (244.9)	11,715 (259.0)	--	--	--
Chicago	21,921 (234.4)	18,899 (201.3)	25,036 (265.2)	19,581 (206.2)	23,931 (250.1)	--	--	+22
Denver	768 (33.0)	1,054 (44.7)	1,272 (52.9)	1,308 (53.3)	1,321 (52.7)	+72	--	--
Detroit	3,236 (71.9)	4,801 (106.8)	5,951 (132.6)	5,591 (125.4)	5,644 (127.5)	+74	-5	--
Houston	449 (8.6)	185 (3.5)	462 (8.4)	372 (6.6)	629 (11.0)	--	--	--
Miami/Dade	2,336 (99.9)	2,721 (115.5)	1,058 (44.5)	... ⁴	... ⁴	⁵	⁵	⁵
Minneapolis/St. Paul	1,189 (38.3)	1,023 (32.7)	1,309 (41.4)	1,691 (52.9)	1,651 (51.1)	--	--	--
New York City	13,383 (163.8)	18,179 (221.3)	17,892 (216.9)	16,884 (203.2)	16,084 (192.3)	--	-10	--
Phoenix	1,772 (47.7)	1,357 (35.0)	2,085 (51.7)	2,364 (56.7)	2,712 (63.3)	+53	--	--
San Diego	950 (32.4)	1,145 (39.1)	1,393 (47.4)	876 (29.6)	1,449 (48.3)	--	--	+65
San Francisco	2,424 (141.7)	3,138 (182.9)	1,994 (115.4)	1,993 (114.1)	1,616 (91.3)	-33	--	--

¹Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

²It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.

³This column denotes statistically significant ($p < .05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol "--" indicates no statistically significant changes in the estimates between the reporting periods shown.

⁴Three dots (...) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count less than 30 has been suppressed.

⁵No significance tests could be performed due to lack of data for 1 or more of the comparison years.

SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/04/2009

Appendix Table 3.3. Weighted Estimates¹ of Emergency Department (ED) Visits² for Nonmedical Use of Pharmaceuticals³ Involving Opiates/Opioids, and Rates per 100,000 Population, for 11 CEWG Areas: 2004–2008

CEWG Areas	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2008	Percent and Direction of Change, 2004-2008 ⁴ (%)	Percent and Direction of Change, 2006–2008 ⁴ (%)	Percent and Direction of Change, 2007–2008 ⁴ (%)
Boston	3,982 (89.4)	4,417 (99.2)	4,164 (93.2)	5,346 (119.0)	5,919 (130.9)	+49	+42	--
Chicago	4,964 (53.1)	5,054 (53.8)	5,949 (63.0)	5,178 (54.5)	6,373 (66.6)	+28	--	+23
Denver	851 (36.6)	1,450 (61.5)	1,963 (81.7)	2,479 (101.1)	2,977 (118.8)	+250	+52	+20
Detroit	2,725 (60.6)	4,149 (92.3)	4,769 (106.3)	6,068 (136.1)	6,676 (150.9)	+145	+40	+10
Houston	4,170 (80.3)	3,211 (60.6)	5,915 (107.8)	6,935 (123.9)	5,556 (97.0)	+33	--	--
Miami/Dade	464 (19.8)	730 (31.0)	654 (27.5)	741 (31.1)	711 (29.6)	+53	--	--
Minneapolis/St. Paul	1,878 (60.5)	1,923 (61.4)	2,687 (84.9)	3,263 (102.0)	4,262 (131.9)	+127	+59	+31
New York City	3,615 (44.2)	5,291 (64.4)	6,245 (75.7)	7,193 (86.6)	7,984 (95.5)	+121	+28	--
Phoenix	2,629 (70.7)	2,762 (71.3)	3,593 (89.0)	3,941 (94.6)	4,412 (103.0)	+68	+23	+12
San Diego	875 (29.9)	1,304 (44.5)	1,437 (48.9)	1,517 (51.2)	2,416 (80.5)	+176	+68	+59
San Francisco	1,055 (61.7)	2,172 (126.6)	1,703 (98.5)	1,369 (78.3)	1,784 (100.8)	+69	--	+30

¹Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

²It should be noted that summing or combining visits for drugs, cocaine, heroin, other opiates/opioids, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.

³Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.

⁴This column denotes statistically significant ($p < .05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol "--" indicates no statistically significant changes in the estimates between the reporting periods shown.

SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/04/2009

Appendix Table 3.4. Weighted Estimates¹ of Emergency Department (ED) Visits² for Nonmedical Use of Pharmaceuticals³ Involving Benzodiaepines, and Rates per 100,000 Population, for 11 CEWG Areas: 2004–2008

CEWG Areas	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2008	Percent and Direction of Change, 2004-2008 ⁴ (%)	Percent and Direction of Change, 2006–2008 ⁴ (%)	Percent and Direction of Change, 2007–2008 ⁴ (%)
Boston	4,096 (92.0)	4,160 (93.4)	4,241 (94.9)	5,321 (118.4)	5,516 (122.0)	+35	+30	--
Chicago	3,369 (36.0)	3,208 (34.2)	3,660 (38.8)	3,782 (39.8)	4,502 (47.0)	+34	+23	+19
Denver	551 (23.7)	1,049 (44.5)	1,379 (57.4)	1,689 (68.8)	1,800 (71.8)	+227	+30	--
Detroit	2,111 (46.9)	2,878 (64.0)	3,125 (69.7)	4,083 (91.6)	4,887 (110.4)	+131	+56	+20
Houston	6,603 (127.1)	4,666 (88.0)	7,441 (135.6)	7,750 (138.4)	7,019 (122.5)	--	--	--
Miami/Dade	1,372 (58.7)	1,788 (75.9)	1,497 (63.0)	1,362 (57.2)	1,524 (63.5)	--	--	--
Minneapolis/St. Paul	943 (30.3)	883 (28.2)	1,337 (42.3)	1,916 (59.9)	2,014 (62.4)	+114	+51	--
New York City	2,213 (27.1)	2,888 (35.2)	3,238 (39.2)	3,519 (42.3)	3,828 (45.8)	+73	--	--
Phoenix	2,269 (61.1)	2,247 (58.0)	3,082 (76.4)	3,030 (72.7)	3,472 (81.1)	+53	--	+15
San Diego	755 (25.8)	1,075 (36.7)	1,225 (41.7)	1,150 (38.8)	1,662 (55.4)	--	+36	+45
San Francisco	775 (45.3)	1,253 (73.0)	896 (51.8)	998 (57.1)	1,016 (57.4)	--	--	+2

¹Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

²It should be noted that summing or combining visits for drugs, cocaine, heroin, other opiates/opioids, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.

³Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.

⁴This column denotes statistically significant ($p < .05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol "--" indicates no statistically significant changes in the estimates between the reporting periods shown.

SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/04/2009

Appendix Table 3.5. Weighted Estimates¹ of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Methamphetamine², and Rates per 100,000 Population for 11 CEWG Areas: 2004–2008

CEWG Areas	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2008	Percent and Direction of Change, 2004–2008 ³ (%)	Percent and Direction of Change, 2006–2008 ³ (%)	Percent and Direction of Change, 2007–2008 ³ (%)
Boston	99 (2.2)	222 (5.0)	141 (3.2)	203 (4.5)	220 (4.9)	+123	--	--
Chicago	201 (2.2)	253 (2.7)	183 (1.9)	159 (1.7)	187 (2.0)	--	--	--
Denver	756 (32.5)	1,794 (76.1)	1,381 (57.5)	1,216 (49.6)	890 (35.5)	--	-36	-27
Detroit	... ⁴	... ⁴	... ⁴	... ⁴	... ⁴	5	5	5
Houston	468 (9.0)	605 (11.4)	668 (12.2)	705 (12.6)	624 (10.9)	--	--	--
Miami/Dade	60 (2.6)	132 (5.6)	70 (2.9)	... ⁴	... ⁴	5	5	5
Minneapolis/St. Paul	1,741 (56.1)	2,209 (70.5)	1,120 (35.4)	1,103 (34.5)	1,001 (31.0)	-42	--	--
New York City	214 (2.6)	330 (4.0)	296 (3.6)	325 (3.9)	295 (3.5)	--	--	--
Phoenix	3,476 (93.5)	4,119 (106.3)	4,706 (116.6)	3,762 (90.3)	3,002 (70.1)	--	-36	--
San Diego	1,470 (50.2)	2,601 (88.7)	2,297 (78.2)	1,551 (52.4)	1,625 (54.1)	+10	-29	--
San Francisco	2,149 (125.7)	4,343 (253.1)	2,429 (140.5)	1,794 (102.6)	1,670 (94.3)	-22	-31	--

¹Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

²It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.

³This column denotes statistically significant ($p < .05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol "--" indicates no statistically significant changes in the estimates between the reporting periods shown.

⁴Three dots (...) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count less than 30 has been suppressed.

⁵No significance tests could be performed due to lack of data for 1 or more of the comparison years.

SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/04/2009

Appendix Table 3.6. Weighted Estimates¹ of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Marijuana², and Rates per 100,000 Population for 11 CEWG Areas: 2004–2008

CEWG Areas	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2008	Percent and Direction of Change, 2004-2008 ³ (%)	Percent and Direction of Change, 2006–2008 ³ (%)	Percent and Direction of Change, 2007–2008 ³ (%)
Boston	5,252 (117.9)	5,661 (127.1)	5,414 (121.2)	6,556 (145.9)	7,624 (168.6)	+45	+41	+16
Chicago	11,544 (123.4)	10,808 (115.1)	11,644 (123.4)	11,335 (119.4)	12,382 (129.4)	--	--	+9
Denver	1,172 (50.4)	2,126 (90.1)	3,287 (136.8)	3,605 (146.9)	3,793 (151.3)	+224	--	--
Detroit	2,935 (65.2)	4,496 (100.0)	5,268 (117.4)	6,207 (139.3)	6,267 (141.6)	+114	--	--
Houston	8,214 (158.2)	5,003 (94.3)	7,219 (131.6)	6,643 (118.7)	10,537 (184.0)	--	--	+59
Miami/Dade	3,755 (160.7)	5,192 (220.3)	4,333 (182.3)	3,576 (150.1)	3,378 (140.8)	--	--	--
Minneapolis/St. Paul	4,455 (143.5)	4,467 (142.6)	4,302 (135.9)	5,757 (180.0)	5,617 (173.9)	--	--	--
New York City	5,920 (72.5)	10,192 (124.1)	12,938 (156.8)	14,500 (174.5)	16,204 (193.7)	+174	+25	--
Phoenix	2,671 (71.9)	2,830 (73.1)	3,730 (92.4)	3,433 (82.4)	3,374 (78.8)	--	--	--
San Diego	837 (28.6)	1,644 (56.1)	1,660 (56.5)	1,622 (54.8)	2,067 (68.9)	+147	+25	--
San Francisco	1,166 (68.2)	2,179 (127.0)	1,566 (90.6)	1,549 (88.6)	1,629 (92.0)	--	--	+5

¹Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

²It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.

³This column denotes statistically significant ($p < .05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol "--" indicates no statistically significant changes in the estimates between the reporting periods shown.

SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/04/2009

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